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AN ANALYSIS OF THE DEFENSE HEALTH AGENCY TRANSITION PLAN WITH REGARD TO THE IMPACT ON CONTRACTING OPERATIONS WITHIN THE MILITARY HEALTH SYSTEM

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June 2020

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This analysis examines the Defense Health Agency's (DHA) transition plan with regard to contracting operations within the Military Health System (MHS). First, the study addresses various Government Accountability Office (GAO) cases relating to healthcare reform. The documents establish a pattern of the government's attempt to address needed change in the MHS. Next, the analysis provides an overview of contracting capabilities from each service component. The findings highlight the impact of these capabilities as a result of DHA's authority, direction, and control (ADC) of the MTFs. Third, the analysis addresses the efficiencies in the acquisition process. The findings identify any gained efficiencies as described in DHA's Quadruple Aim initiative. Additionally, the analysis addresses the Medical Q-Service contracting vehicle. The results highlight cost-savings using this strategic, contract vehicle and compare the data to market trends and government expenditures. The results of this study will lend a better understanding of the operational and strategic impact of the DHA transition plan. Last, the recommendations focus on optimizing existing operational capabilities and processes and increasing contracting efficiencies. The goal is to improve the overall ability to conduct medical contracting operations effectively while reducing costs and maintaining a high level of medical capability.

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LIST OF ACRONYMS AND ABBREVIATIONS

AAMC	Association of American Medical Colleges
ACC	Army Contracting Command
ACWS	Army Contract Writing System
ADC	authority, direction and control
AD HCA	Assistant Director for Health Care Administration
AFAR	Army Federal Regulation
AFFAR	Air Force Federal Acquisition Regulation
AFICC	Air Force Installation Contracting Center
AFMS	Air Force Medical Service
BAMC	Brooke Army Medical Center
BJACH	Bayne-Jones Army Community Hospital
BUMED	Bureau of Medicine and Surgery
CAE	Component Acquisition Executive
COP	Common Operating Picture
CON	Contracting Squadron
CSP	Contract Services Providers
CRDAMC	Carl R. Darnall Army Medical Center
DAS (C)	Deputy Assistant Secretary of Contracting
DENTAC	Dental Activities
DFARS	Defense Federal Acquisition Regulation Supplement
DHA	Defense Health Agency
DHAPI	Defense Health Agency Procedural Instruction
DHP	Defense Health Program
DOD	Department of Defense
DS	Direct Support
FAR	Federal Acquisition Regulation
FPDS-NG	Federal Procurement Data System- Next Generation
FTE	Full Time Equivalent

FOC	Full Operating Capability
FORSCOM	Forces Command
FY	Fiscal Year
GAO	Government Accountability Office
GFEB	General Fund Enterprise Business System
GLWACH	General Leonard Wood Army Community Center
GPC	Government Purchase Card
HCA	Head of Contracting Activity
HIPAA	Health Insurance Portability and Accountability Act
HRCO	Health Readiness Contracting Office
ID/IQ	Indefinite Delivery/Indefinite Quantity
IOC	Initial Operating Capability
IPM	Interim Procedures Memorandum
KPP	key performance parameter
LOE	lines of effort
MEDCOM	Medical Command
MAHC	McDonald Army Health Center
MHS	Military Health System
MHSRSP	Military Health System Request Submission Portal
MTF	Military Treatment Facility
MOA	Memorandum of Agreement
MQS	Medical Q-coded Service
NDAA	National Defense Authorization Act
NDS	National Defense Strategy
NMCARS	Navy Marine Corps Acquisition Regulation Supplement
NMLC	Navy Medical Logistics Command
OCONUS	Outside of Continental United States
PALT	Procurement Acquisition Lead Time
PEO	Program Executive Office
PCF	Paperless Contract File

PSC	product service codes
PD2	Procurement Desktop Defense
PIEE	Procurement Integrated Enterprise Environment
QPP	Quadruple Aim Performance Plan
RHCO-C	Regional Health Contracting Office-Central
SAT	Simplified Acquisitions Threshold
SCO	Senior Contracting Official
SPS	Standard Procurement System
SSO	Small Market and Stand-alone Organization
TAMC	Tripler Army Medical Center
tIMO	transitional Intermediate Management Organization
TOF	Transfer of Function
USAHCA	United States Army Health Contracting Activity
USC	United States Code
VCE	Virtual Contracting Enterprise
VCE-BI	Virtual Contracting Enterprise Business Intelligence
WAMC	Womack Army Medical Center

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This research was made possible by the unwavering support of the DHA leadership and support personnel. Special thanks to the U.S. Army Medical Command (MEDCOM) and USAHCA for unfettered access to data systems, leadership forums, and other resources, which was critical in the development of this research with the goal of capturing an impartial analysis of the MHS. Next, we would like to thank the MEDCOM 8X Deputy Consultant LTC Owen Roberts for setting the learning conditions of the Long-Term Health Education & Training (LTHET) Acquisition and Procurement Internship Program (APIP). Through this learning environment, he and supporting cast enabled a balanced contracting training atmosphere coupled with an invaluable opportunity to develop future Medical Service Corps acquisition professionals through Naval Postgraduate School. Finally, special thanks to our Naval Postgraduate School Advisor Professor Howard Pace and USAHCA Senior Contracting Official (SCO) Colonel Christopher Todd. Their mentorship, expertise, and selfless support postured this research to remain on schedule, structured, and tailored for public reading and insight.

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I. INTRODUCTION

A. BACKGROUND

The Military Health System (MHS) is a core system of the Department of Defense (DOD) that serves over 9.6 million beneficiaries and has a budget for the fiscal year 2020 of $49.5 billion (Mendez, 2019). The MHS benefit administered by the military medical service departments of the Army, Air Force, and Navy. These departments include Army Medical Command (MEDCOM), Air Force Medical Service, Navy Bureau of Medicine and Surgery (BUMED), and the Defense Health Agency (DHA). Each service component provides separate contracting support to their designated Military Treatment Facilities (MTF) as well. The Army is the only department with a medical contracting activity, the United States Army Health Contracting Activity (USAHCA), which is outfitted with both military and civilian workforce.

The MHS reform has been one of the top three priorities of Congress in the last three National Defense Authorization Acts (NDAA) 2016 through 2019. Most notably, NDAA 2017 directed DHA to assume administrative responsibilities of each MTF from the service components in the United States (*National Defense Authorization Act for Fiscal Year 2017*, 2016). As a result of this directive, multiple lines of effort (LOE) were created for each service component to maximize support of the initiatives as each department postures its formations to execute the National Defense Strategy (NDS).

To optimize one of the most comprehensive healthcare systems in the world, Congress must reform an antiquated MHS through modernization, streamlining, and collaboration. To facilitate the reform, in accordance with Section 702 of NDAA 2017 and NDAA 2019, the DOD laid out a plan to transition MTFs from the service to the DHA over a three-year time frame. The purpose of the change of the MHS is to implement a unified system of readiness and healthcare delivery (*National Defense Authorization Act for Fiscal Year 2017*, 2016). Upon completion of the transition, DHA will assume all MTFs within the DOD through the utilization of its market-based management model (Defense Health Agency [DHA], 2019).

One of the key focus areas of this research paper is the impact on contracting operations within the MHS. The synchronization of contracting capabilities to provide a unified platform to support healthcare services and support is critical throughout the transition process. This research aims to highlight the LOEs through the lens of the USAHCA, the Army's medical contracting arm, as the organization undergoes a variety of structural and contracting policy changes in order to aid DHA in the desired end state of an integrated healthcare system.

B. PURPOSE OF RESEARCH

This research aims to analyze previous and current acquisition strategies of the MHS through the perspective of Army medical contracting. Further examination will address key elements and significant milestones of the DHA transition process and implementation plan. The second objective of this research is to identify potential risks, capability gaps, and opportunities for mitigation as DHA continues its implementation strategy of a unified healthcare system.

C. RESEARCH QUESTIONS

This research addresses the following research questions:

1. How has the contracting capabilities and processes from each service component been affected upon inception of DHA assuming administrative responsibility of MTFs on 1 October 2018?
2. Is DHA gaining the desired efficiencies in acquisitions and procurement operations after achieving authority, direction, and control (ADC)?
3. Does the Medical Q-coded Service (MQS) strategic sourcing vehicle generate cost-savings?

D. METHODOLOGY

To help answer the research questions, we utilized multiple data tools within the Army acquisition community. These tools included the Virtual Contracting Enterprise (VCE), Virtual Contracting Enterprise Business Intelligence (VCE-BI), Procurement

Desktop Defense (PD2), Procurement Integrated Enterprise Environment (PIEE), Federal Procurement Data System- Next Generation (FPDS-NG), and Beta.Sam.Gov to gather contracting metrics. The goal of the financial data is to identify and analyze trends in respect to DHA's Quadruple Aim initiative. Further information will highlight some of the critical components of DHA's implementation plan and assess some of the strategic, contracting vehicles employed during the transition process. Other research material will come from military regulations, publications, policies, conference forums, and public search engines, which will only be collected from 2016 through May 2020. The intent is to target data collected and analyzed before the DOD response to COVID-19.

E. IMPORTANCE OF RESEARCH

The time for healthcare reform is now. The DOD has longed for efficiency and opportunities to implement cost-saving measures through strategic reform. With the passage of NDAA 2017 and 2019, Congress, along with supporting cast within the DOD service components, is postured to do just that. The business cost of military healthcare exceeds $50 Billion annually, so efforts to employ efficiencies while building a better healthcare system would be a significant achievement for the health and welfare of Service members, Veterans, and family members. DHA has the lead for spearheading this effort. Their strategic approach to consolidate business practices across the services energizes the opportunity to achieve a joint health system. Contracting and procurement services will be a critical function across all services. Opportunities to consolidate and streamline acquisition processes and authority may impose additional complexity throughout the process. This research aims at identifying these factors through holistic research and provides recommendations that will support the DOD's vision of a Joint health system.

F. LIMITATIONS OF RESEARCH

This analysis has several limitations. One limitation is the fact that the data presented is from manual input and human submission. Human error will always be a factor when reviewing information within data systems that are inputted manually. For this research, we will assume that the data presented is accurate to the extent that it has been vetted for public release.

Another limitation is that information retrieved from public testimony, telecast, or open forums is subjective. One can assume that each presenter or public figure must present their viewpoint or provide public information that may be within the bounds of their organizations or position of authority. Thus, the information gathered within these types of forums are subjective. For this research, information gathered under these resources will be used as supporting evidence within this framework.

G. ORGANIZATION OF REPORT

This paper consists of five chapters. The first chapter provides the background of the analysis, the purpose of the study, research questions, methodology, importance of the research, and the limitations experienced throughout the research. The second chapter is the literature review. This chapter will highlight the MHS transition process's critical stakeholders and address critical elements within DHA's implementation plan regarding contracting operations. The third chapter will describe the methodology of the research. This chapter will highlight DOD's data and information systems that will provide evidence of efficiencies and cost-saving progress throughout the transition. The fourth chapter will address capability gaps through comparative analysis. The goal of this chapter is to assess the impact of planned milestones and actual events, according to DHA's published transition timeline. The last chapter will bring the paper to a conclusion and present areas of emphasis that may require additional resources and considerations for DHA in their continued progression of a united military health system.

H. SUMMARY

This chapter of the research paper provided the introduction and background of the DHA transition and the key stakeholders involved that will aid the transformation with the goal of efficiency as the driving force throughout the process. The purpose of this analysis highlighted the intent of the research. Next, the chapter presented research questions that will frame the information and data collected through the process. In addition, this section outlined the methods that will be employed to highlight critical sources that will support the study's framework. Furthermore, the chapter outlined the importance of the study and how the transformation process will gain efficiencies, identify capability gaps, and address

points of contention. However, some limitations will impact the research, but through validated resources, increase the validity and reliability of the information. Lastly, the organization of this research is in a chronological manner that will be conducive for public reading and bring awareness to those familiar with the transition and those that may be unaware of the ongoing efforts of MHS reform. The next chapter presents a history of the MHS Reform, congressional directives, Government Accountability Office (GAO), and supporting documents that led to the NDAA 2017 directive for a complete transition of MTFs to DHA.

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II. BACKGROUND/LITERATURE REVIEW

A. INTRODUCTION

The following background information includes federal law, policies, regulations, documented events, and change theories. This chapter begins with Kotter's 8-Step Process for transforming an organization. DHA Component Acquisition Executive (CAE), Dr. Barclay Butler, highlights this particular theory to pinpoint some of the elements for organizational changes that DHA and other stakeholders may exhibit as part of the MTF transition. Next, the information addresses numerous GAO cases relating to MHS reform. Then, the information addresses NDAA 2017, the congressional directive that designates DHA as the lead agent for the MTF transition. Additional information will highlight the DOD's transitional reform initiatives followed by an overview of DHA's Plan 3 Implementation, which provides details of how DHA intends to accomplish the transition process of military MTFs.

B. KOTTER'S 8-STEP PROCESS FOR TRANSFORMING AN ORGANIZATION

"In any type of transformation, the shift in culture is key" (Butler, 2018). The statement published in Fed Health IT; Dr. Butler, promotes the quadruple aim initiation of the MHS healthcare transformation. He references Kotter's 8-Step Process for Transforming an Organization. Figure 1 depicts the 8-step process. John Kotter, author and strategist of the book *Leading Change: Why Transformation Efforts Fail*, references eight steps that organizations should integrate as they undergo some form of organizational transformation. The first step under this theory is to create a sense of urgency. By creating a sense of urgency, organizations can identify the level of complacency within the workforce and employ the necessary resources to energize the organization to accept the change (Kotter, 2017).

Step two focuses on building a guiding coalition. Mr. Kotter explains that a coalition is a "central to the network and consists of volunteers representing all levels, departments, and skills in the hierarchy" (Kotter, 2017). Step 3 is creating a vision. Kotter

expresses that “an organization must create a vision which focuses on maximizing opportunities and appeals to the emotions of those impacted by the transformation” In addition, the transformation plan should include strategic initiatives that achieve the vision. Step 4 focuses on enlisting a volunteer army. Mr. Kotter explains that it is a “guiding coalition’s responsibility to communicate the vision and the strategy in such a way that employees buy into the message, commit to it, and feel motivated to volunteer to be a part of the change” (Kotter, 2017). Step 5 of transforming an organization focuses on enabling actions by removing barriers.

> Anything that gets in the way of achieving the vision is identified and solved. Kotter sees suitably qualified and skilled members of the network volunteering deal with an identified barrier and then implementing the solution within the hierarchy. (Kotter, 2017)

Step 6 is to generate short term wins. Mr. Kotter states, “the guiding coalition must celebrate and communicate visible and significant short-term wins in order to generate motivation and confirm that decisions and actions are benefiting the organization” (Kotter, 2017). Next, is to sustain acceleration “the sense of urgency around the big opportunity must be maintained with new projects, themes, and volunteers in order to invigorate people and the process” (Kotter, 2017). The last step of the process is to institute change. Mr. Kotter states,

> Change needs to be assimilated into the organization. It needs to be normalized in the culture of the organization and the link made between the change and organizational success. Methods to ensure leadership development and succession need to be integrated into the organization. (Kotter, 2017)

Dr. Butler’s reference to Kotter’s 8-step process to organizational change is a prelude to DHA’s implementation strategy, but the overhaul of the MHS has been on the DOD’s agenda for several years. The following GAO reports highlighting some of the key findings, which eventually led to the passage of NDAA 2017, directing DHA to take full ADC of all MTFs.

Figure 1. Kotter's Eight Steps to Transforming Your Organization. Source: Kotter (1995).

C. GAO-13-322, DEPARTMENT OF DEFENSE NEEDS A STRATEGIC APPROACH TO CONTRACTING FOR HEALTH CARE PROFESSIONALS

In May 2013, Per NDAA 2012, the GAO published a report addressing contracting for medical services. At this time, the DOD was in the process of implementing its plans to establish the DHA. According to the report's findings, the military departments execute the majority of their contracting for health care professionals separately and do not have an enterprise-wide strategy in place. Secondly, the military departments attempted to consolidate requirements and issue multiple-award contracts, which led to successful outcomes; however, a need for more consolidation remained (Woods, 2013). Last, the GAO reported that competition was created between the military departments unknowingly when contracting for similar health care professionals in the same region (Woods, 2013). The GAO recommendations included that the Secretary of Defense should "develop a

DOD-wide strategic approach to contracting for health care professionals" (Woods, 2013). In conclusion, the GAO report stated:

> In the absence of a DOD-wide approach to acquiring medical services, each military department takes a fragmented approach to contract for medical professionals without considering the collective needs of the MHS. However, according to the report, DOD is in the process of revising the governance structure of the MHS to centralize certain functions, such as acquisitions, that are fragmented among the military departments. Consequently, now is a particularly opportune time to revisit the need for a DOD-wide strategic sourcing strategy with both near-term and long-term dimensions, including reliable and detailed agency-wide data. Without such a strategy, the Military Health System may be missing opportunities for acquiring professional medical services in the most cost-effective manner. (Woods, 2013)

The next GAO report addresses DOD to submit detailed plans on its efforts to reform the MHS.

D. GAO-14-49, DEFENSE HEALTH CARE REFORM: ADDITIONAL IMPLEMENTATION DETAILS WOULD INCREASE TRANSPARENCY OF DOD'S PLANS AND ENHANCE ACCOUNTABILITY

In November 2013, the GAO published a report in which the NDAA 2013 required the DOD to "provide three submissions detailing its plan to reform its MHS governance structure and also mandated that GAO submit an analysis of DOD's first two submissions" (Farrell, 2013). This particular report addressed 87 performance measures and seven goals for MHS reform. The GAO further highlighted critical benchmarks related to the formation of the DHA. The information addressed estimates of authorized staff needed for the DHA headquarters and highlighted "estimated implementation costs and aggregated cost-savings estimates for the consolidation of four shared services" (Farrell, 2013). The report highlighted that:

> Health care consumes an increasingly large portion of the defense budget, DOD leadership has acknowledged the need to reduce duplication and overhead, operate its health system as efficiently as possible, and realize savings in the MHS through the adoption of common clinical and business processes. (Farrell, 2013)

Figure 2 illustrates the organizational structure of the military health system before 1 October 2013.

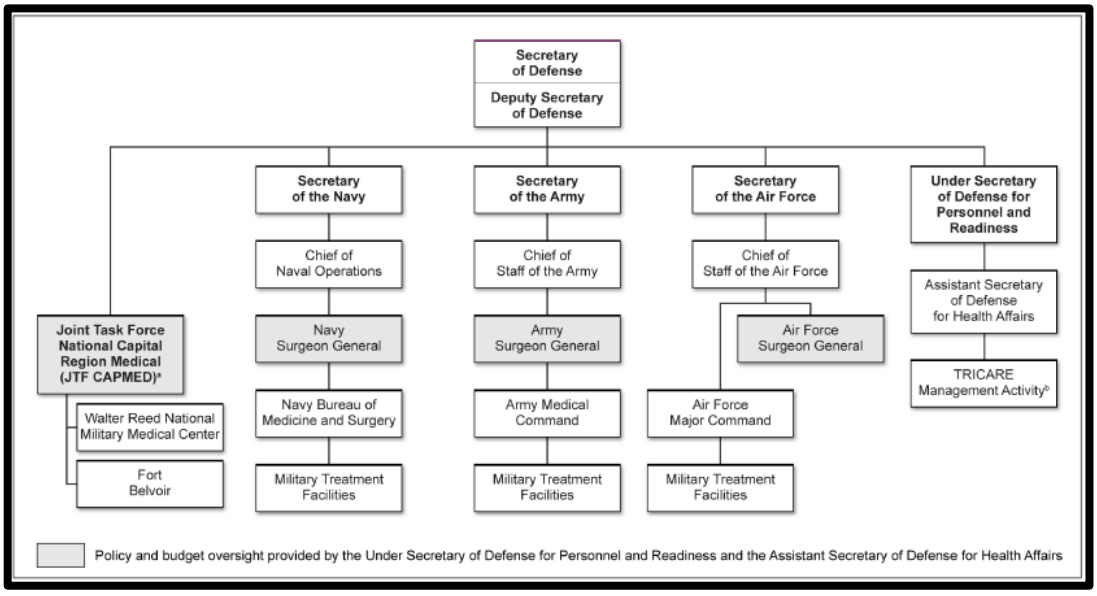

Figure 2. Organizational Structure of the Military Health System Prior to October 1, 2013. Source: Farrell (2013).

Additionally, the report addresses six areas throughout the country, which the DOD designated as "enhanced Multi-Service Markets" (Farrell, 2013). Multi-Service Markets are defined as "areas in which more than one DOD component provides military health care services" (Farrell, 2013). Each of these markets will implement a "5-year performance plan to produce improvements in clinical and business practices and cost, infrastructure, and personnel reductions" (Farrell, 2013). Additionally, the GAO report addressed seven goals to support the DOD overarching strategic goals for greater system integration of the MHS:

1. promote more-effective and efficient health care operations through enhanced enterprise-wide shared services
2. deliver more-comprehensive primary care and integrated health services using advanced patient-centered medical home
3. coordinate care over time and across treatment settings to improve outcomes in the management of chronic illness, particularly for patients with complex medical and social problems

4. match personnel, infrastructure, and funding to current missions, future missions, and population demand
5. establish more inter-service standards and metrics, and standardize processes to promote learning and continuous improvement
6. create enhanced value in military medical markets using an integrated approach specified in 5-year business performance plans
7. align incentives with health and readiness outcomes to reward value creation. (Farrell, 2013)

The next GAO report addresses the need for senior leader involvement in achieving cost savings in the MHS.

E. GAO-14-396T, SUSTAINED SENIOR LEADERSHIP NEEDED TO FULLY DEVELOP PLANS FOR ACHIEVING COST SAVINGS

In February 2014, the GAO released a report titled "Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings." This report highlighted that the DOD cost to maintain the current MHS would increase by approximately $20 billion by 2028 (Farrell, 2014). This particular report addressed previous studies in which the DOD considered efforts to overhaul the MHS. The report noted that in 2006, the DOD deliberated maintaining the structure of the MHS in place, but considered shared-services to consolidate standard MHS functions. To streamline these efforts, the DOD announced the formation of the DHA with an effective date of 1 October 2013. Upon inception, the DOD charged the DHA with seven focused goals:

1. consolidate functions (shared services) common to DOD
2. deliver more-integrated health care in areas with more than one military service
3. establish more-standardized processes
4. more-closely align financial incentives with health and readiness outcomes,
5. match other resources with missions
6. deliver more primary care and other health services, and
7. better coordinate care over time and across treatment settings. (Farrell, 2014)

The next GAO case addresses the organizational structure of the medical force.

F. GAO-16-820, DOD NEEDS FURTHER ANALYSIS OF THE SIZE, READINESS, AND EFFICIENCY OF THE MEDICAL FORCE

In September 2016, the GAO released a report titled "DOD Needs Further Analysis of the Size, Readiness, And Efficiency of The Medical Force. In this particular report, the GAO studied "weaknesses within the MHS and to leverage advances in civilian business practices" (Farrell, 2016). The study identified several deficiencies in the medical workforce. In addition, research revealed the DOD did not optimize methods to capitalize on cost-savings. The GAO suggests several recommendations. One recommendation was to "conduct a new analysis of the required number of active-duty and civilian medical personnel that mitigates known limitations" (Farrell, 2016). Furthermore, the GAO recommended that the DOD develop a strategy to maintain providers' clinical skills and increase the output of active duty-providers. Lastly, the GAO highlighted that the DOD should provide further detail in cost estimations when considering changes to medical facilities. The next section addresses the release of NDAA 2017.

G. NDAA 2017

The NDAA is a succession of federal laws outlying the budget and expenditures of the DOD. Over the past several decades, the MHS has been one of the major cost-drivers of delivery medical care to Warfighters, veterans, and family members. Numerous government entities have indicated a need to restructure the MHS (Mendez, 2019). As a result, the NDAA 2017 section 702 passed into law as an initiative to create an integrated MHS to implement efficiencies and cost-saving strategies across the military MTFs. As of 1 October 2018, all MTFs within the DOD would begin transitioning administration management to the DHA (*National Defense Authorization Act for Fiscal Year 2017*, 2016). In accordance with section 702 of NDAA 2017, the DHA will primarily be responsible for the following shared services: budget, information technology, health care administration and management, administrative policy and procedure, military medical construction, and any other matters the Secretary of Defense determines appropriate (*National Defense Authorization Act for Fiscal Year 2017*, 2016). The next GAO case addresses the transfer of MTFs and efficiency.

H. GAO-19-53, DOD SHOULD DEMONSTRATE HOW ITS PLAN TO TRANSFER THE ADMINISTRATION OF MILITARY TREATMENT FACILITIES WILL IMPROVE EFFICIENCY

In the October 2018 report, the GAO highlighted the DOD's effort to address the following areas:

1. how the DHA will take administrative responsibility of the MTFs
2. efforts to eliminate duplicative activities
3. efforts to maximize efficiencies in the DHA's activities; and
4. reductions of headquarters-level military, civilian, and contractor personnel (Farrell, 2018)

The report highlighted the steps that the DOD took to improve efficiencies, but noted the need to solidify the reduction of "headquarters-level personnel, including contractor personnel, by 10 percent and exclusion of transferring 16 operational readiness and installation-specific medical functions" (Farrell, 2018). One of these excluded operational-readiness functions included: dental care. The next section addresses DOD's implementation plan of how the DHA will transition.

I. DOD IMPLEMENTATION PLAN

The DOD's plan to implement Section 1073c of Title 10, United States Code (USC) in response to Section 702(e)(2) of the NDAA 2017 (Public Law 114-328) was written on 30 June 2018. The report provides recommendations of how DHA will transition administrative management of all MTFs from the military departments through a phased approach over three years (Wilkie, 2018). In accordance with NDAA 2017, the MHS reform is directed by Congress to start transitioning by 1 October 2018 and be completed by 30 September 2021.

> There are three principal efforts underway aimed at maximizing efficiencies in the MHS and improving performance: (a) the redesign and standardization of business and clinical processes to achieve greater efficiencies across the enterprise; (b) the development and implementation of DHA-established Procedural Instructions (DHAPIs); and (c) the

establishment of the Quadruple Aim Performance Plan (QPP). (Wilkie, 2018).

Through a centralized administrative framework, the DOD framed five necessities for transforming the MHS:

- Define medical readiness across all services
- Utilize the new MHS as a platform for medical training
- Standardize shared services
- Improve patient experience
- Modernize TRICARE health plans into two comprehensive options (Wilkie, 2018)

These reform initiatives provide critical instruction which enables DHA to function and operate the MHS as one enterprise. The next section describes DOD's organization of DHA and the key stakeholders that will aid in the transition process regarding current contracting operations.

J. DHA IMPLEMENTATION PLAN

Shortly after designation as the lead agent for the MTF transition, DHA released several versions of its strategic plan to lay the framework for a Joint Health System. DHA aligned its efforts to the Quadruple Aim concept to advance the framework: improve readiness, lower cost, better health care, and better health. Each of these pillars poses a myriad of challenges across the enterprise, so maximum support was required from all stakeholders. Figure 3 provides a systematic timeline of the transformation with a goal of 30 September 2021 to achieve a full transition of the MHS enterprise.

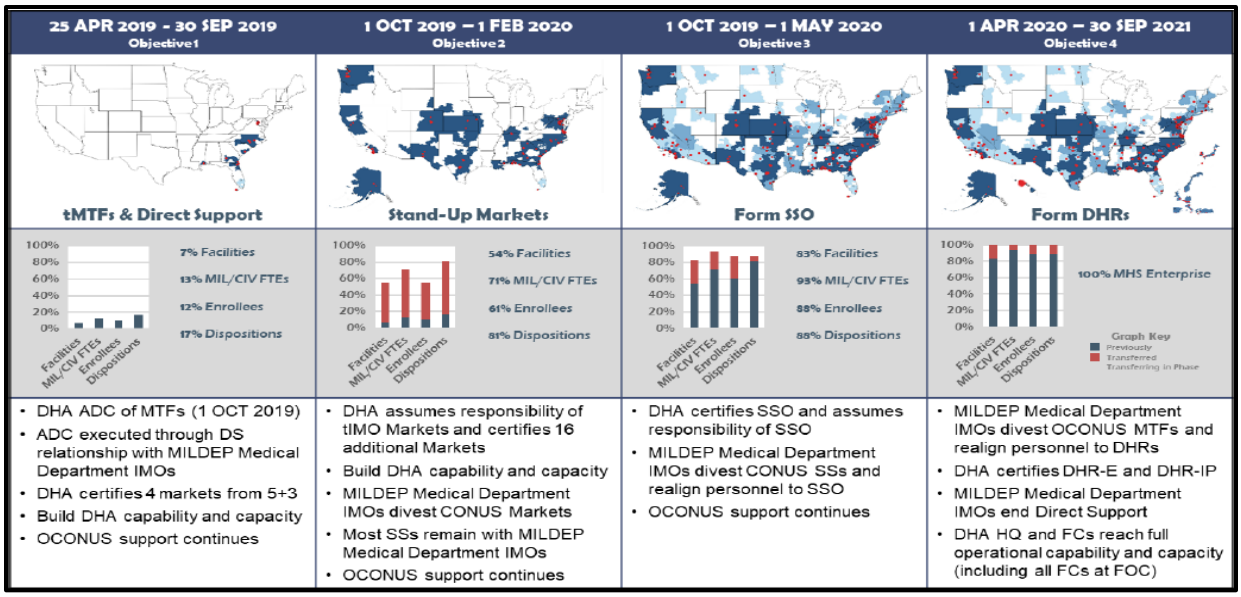

Figure 3. Plan 3 Implementation of NDAA 2017. Source DHA (2019).

1. Market Construct

One of the critical components of the transition strategy is the market construct (DHA, 2019). The goal of this key element is to minimize disruption in operations, both current and associated with future requirements. The additional role of the market-based structure is to manage MTFs and clinics adequately. Figure 4, MHS Market Structure, is a depiction of the market construct. These facilities will be responsible for "generating medical readiness of active duty members, internal medical personnel, and families in their regions (DHA, 2019). Through the restructuring of the market, each medical facility postured to provide immediate resources within their market space and meet the customer-patient demands and readiness of military personnel.

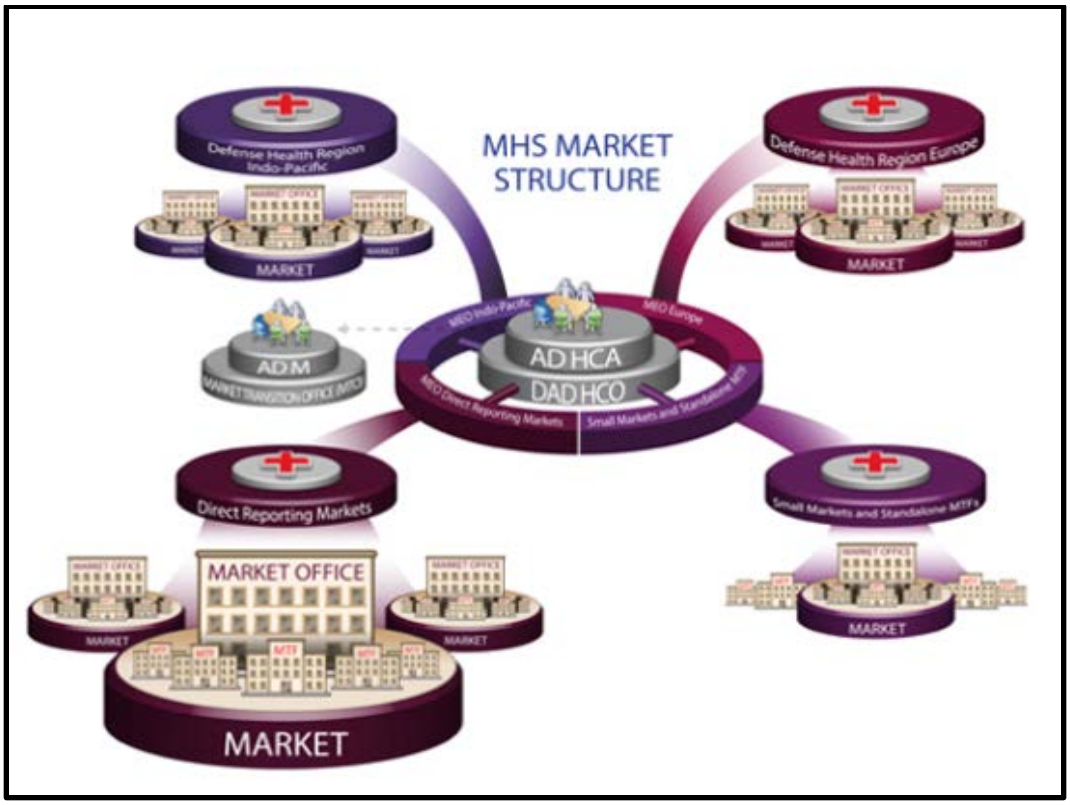

Figure 4. MHS Market Structure. Source: DHA (2019).

a. Large Markets

In areas where there are a significant number of medical facilities and patients, DHA designated these facilities as centers of excellence for specialty care (DHA, 2020). Twenty-one large markets have a significant patient population, as depicted in Figure 5 and Figure 6 (DHA, 2019). More than half of all beneficiaries make up this market and have the highest number of patient encounters as a result. Womack Army Medical Center (WAMC), one of the first MTFs to complete the transition to DHA, is a prime example of how an MTF in a large market will function. Further examination of this particular facility will be revealed in the analysis section of this research.

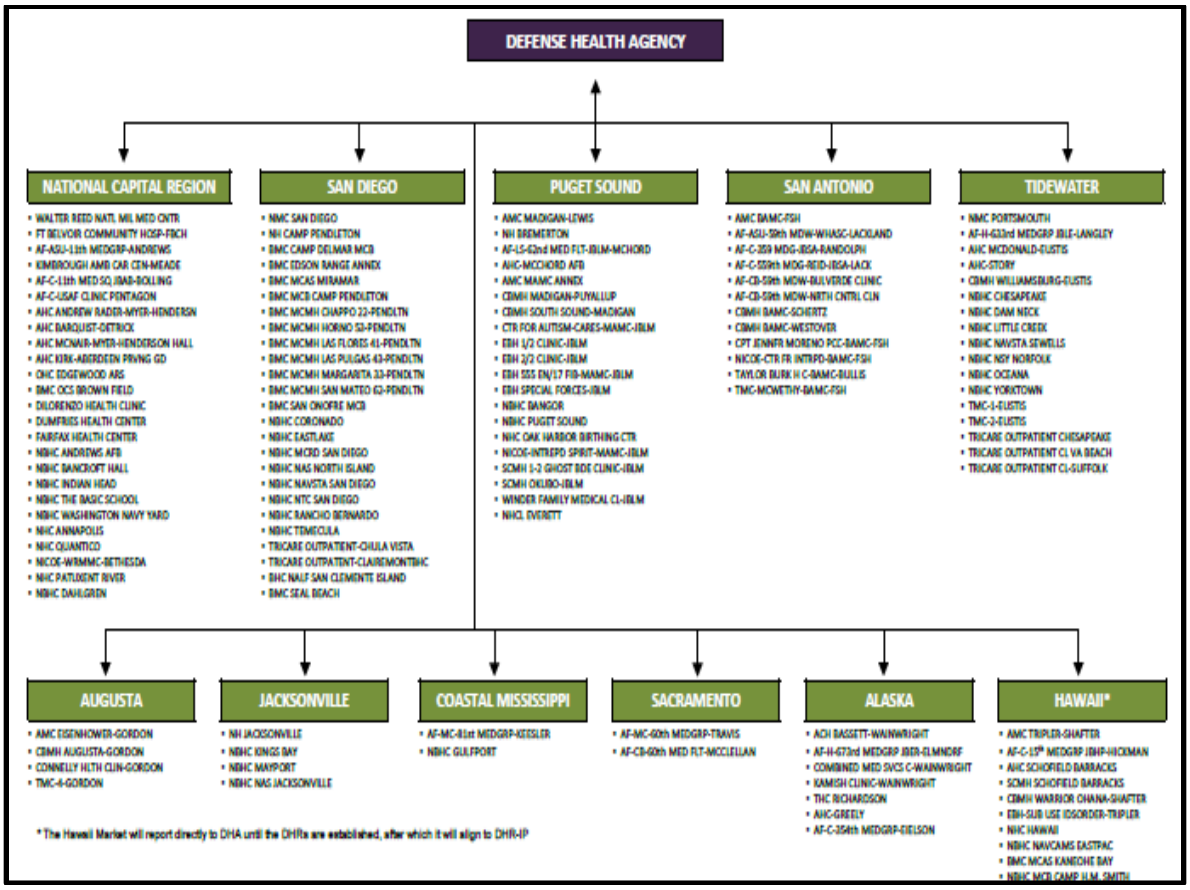

Figure 5. Alignment of Hospitals and Clinics by Market Type. Large Markets. Source: Military Health System (2019).

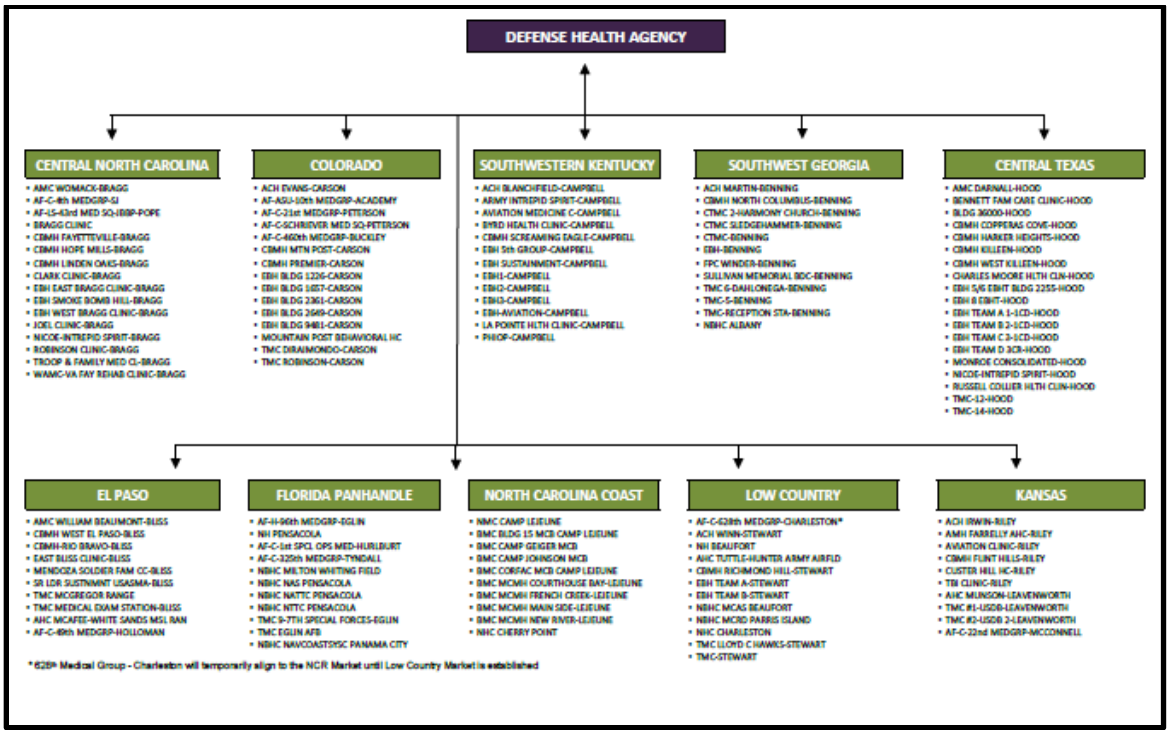

Figure 6. Alignment of Hospitals and Clinics by Market Type. Large Markets. Source: Military Health System (2019).

b. Small Markets

Small Markets and Stand-Alone Organizations (SSO) consists of 16 geographic locations throughout the United States (DHA, 2019). The small markets comprised mostly of community hospitals that provide inpatient care, ambulatory services, and other medical support services (DHA, 2019). Figure 7 and Figure 8 highlights the small markets within the United States. Small markets that align outside of a marked region will report to an SSO for administrative support (DHA, 2019). This will include medical facilities overseas, including Europe and the Pacific market. Figure 9 and Figure 10 depict the market structure outside the Continental United States (OCONUS). The next section will discuss levels of administrative, operational capability.

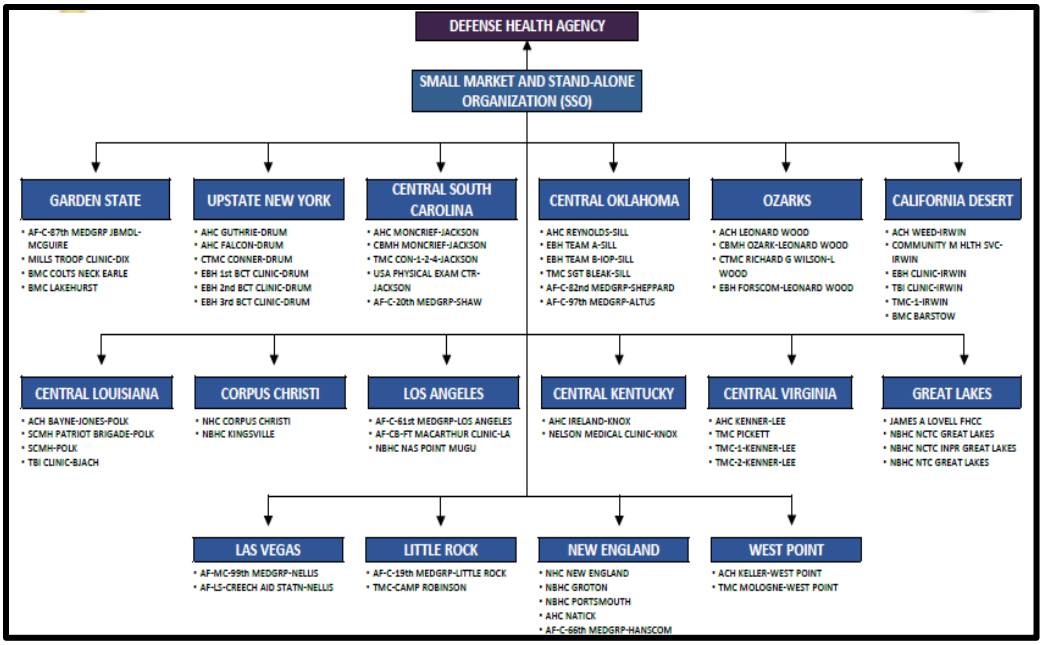

Figure 7. Alignment of Hospitals and Clinics by Market Type. Small Markets and Stand-Alone Organizations. Source: Military Health System (2019).

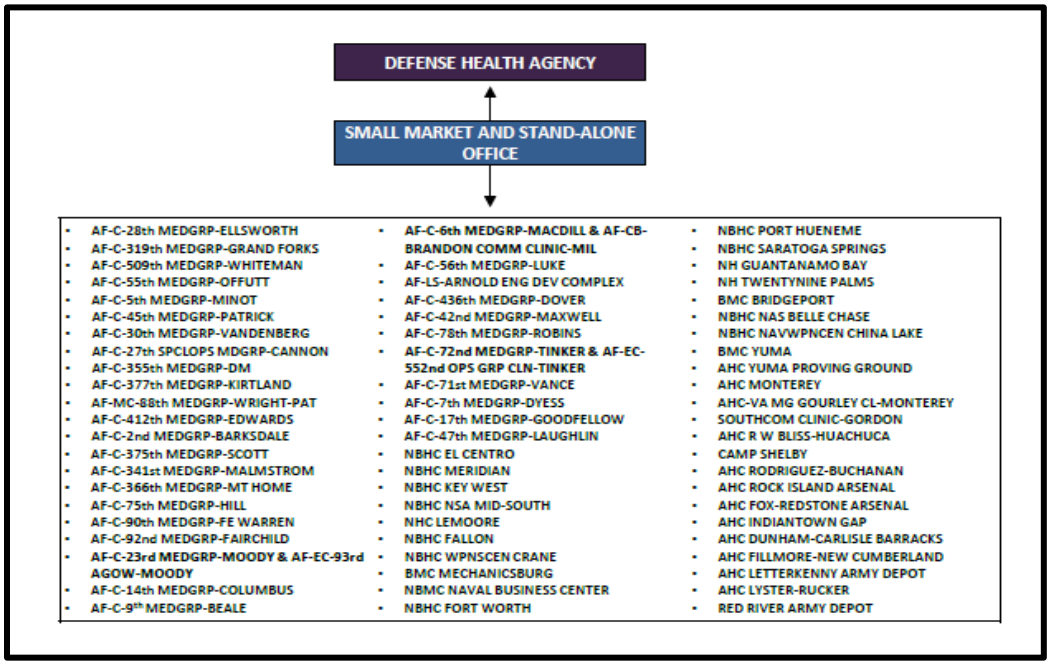

Figure 8. Alignment of Hospitals and Clinics by Market Type. Small Markets and Stand-Alone Organizations. Source: Military Health System (2019).

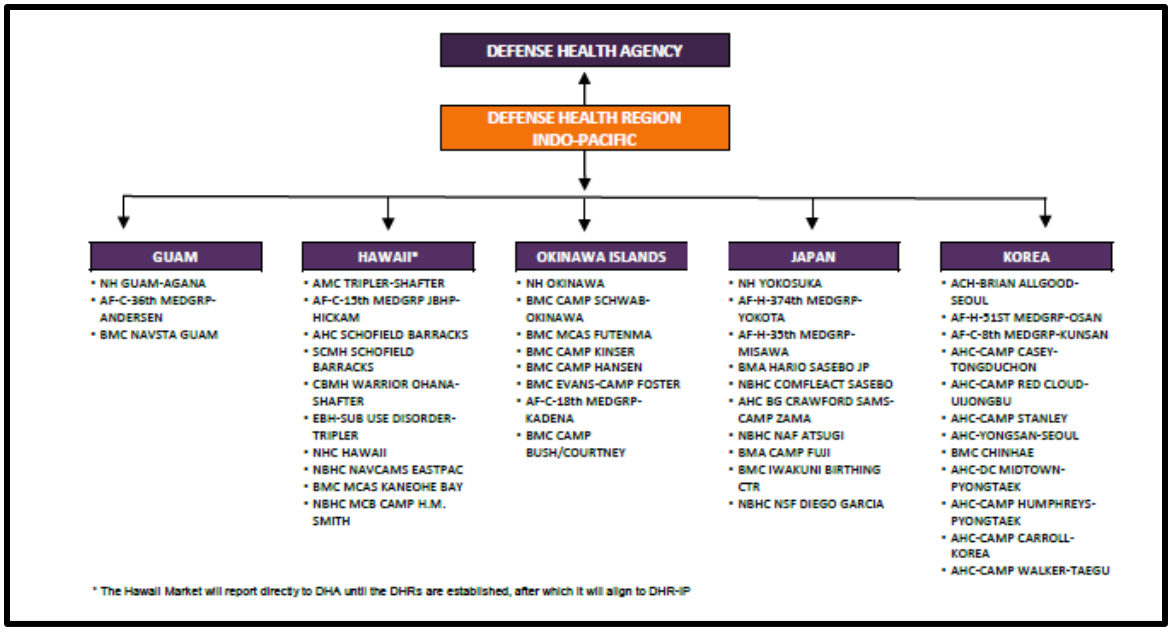

Figure 9. Alignment of Hospitals and Clinics by Market Type. Small Markets and Stand-Alone Organizations, Indo-Pacific. Source: Military Health System (2019).

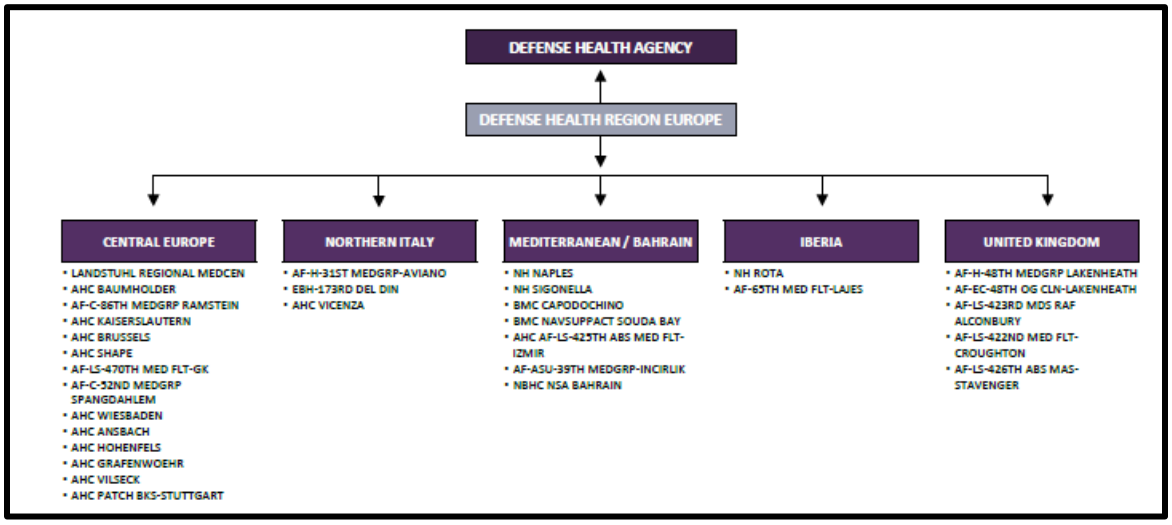

Figure 10. Alignment of Hospitals and Clinics by Market Type. Small Markets and Stand-Alone Organizations, Europe. Source: Military Health System (2019).

2. Levels of Administrative Control

To monitor the status of the MTFs, DHA adopted several definitions to identify thresholds of administrative, operational capability during the transition process. “ADC” indicates that DHA has “full operational control over the MTF in accordance with governing law, regulations, policies, and procedures” (DHA, 2019). Once DHA has ADC, the level of control shifts to an Initial Operating Capability (IOC) (DHA, 2019). When an MTF is determined to have IOC, this indicates that DHA has ADC, but through the use of Direct Support (DS) from each service component Medical Department Intermediate Management Organization (IMO) (DHA, 2019). Figure 11 illustrates the organizational structure of an IMO.

In addition, each Medical Department is responsible for functional support until the conditions-based transfer of authority can be achieved. Once a facility has achieved full operating capability (FOC), this indicates that DHA has ADC to include the functions transferred during IOC with the addition of the MILDEP Medical Departments relinquishment of the responsibility of support operations of the MTFs (DHA, 2019). To avoid any administrative delays in the transition, a Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) may be initiated with the service component to continue DS (DHA, 2019). The previous section highlighted elements of DHA’s transition process from market construct to administrative, operating levels. The next section addresses acquisitions and contracting. The following information will highlight some of the elements of the acquisition and contracting plan and provide further information to the research.

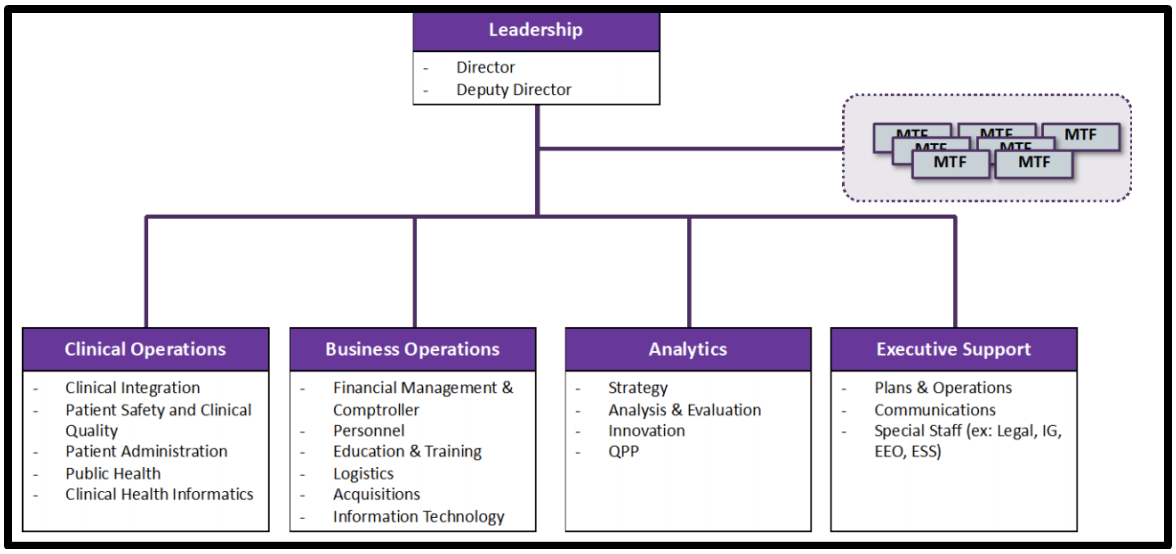

Figure 11. DHA Intermediate Management Organization (IMO) Chart. Source: DHA (2018).

3. Acquisition and Procurement

Appendix #7: Acquisition of the DHA Implementation Plan 3 discusses acquisitions and contracting. Highlighted as one of the shared services, acquisitions, and contracting is an area in which DHA sought to improve efficiency and reduce redundancy (DHA, 2019). DHA aimed to transfer these functions from the MILDEPs to DHA to streamline the acquisition process. Under the current proposal, responsibility for MTF contracting will be transferred to DHA. The Air Force support to the MTFs will continue through a DHA - Air Force Memorandum of Agreement (MOA). The acquisition and procurement function of the NMLC, coupled with entirely of the USAHCA, will be transferred to DHA in a manner that minimizes disruption, preserves organization stability, and maintains supportive relationships during the transition to an optimal organization design structure in support of MTFs (DHA, 2019).

4. Summary

This literature review addressed the aggregation of MHS reform. First, the section highlighted multiple GAO reports, referencing factors, issues, other supporting reasons in which Congress deemed necessary to direct the overhaul of the MHS. Next, the DOD's

plan to implement a transition strategy of the MHS was presented. Additionally, a review of DHA's implementation strategy, to include market construct, and administrative operating capabilities. The goal of this section was to highlight the common theme of reducing redundancies, consolidation, and cost-savings. The next section provides the methodology used to research DHA's implementation strategy and the impact on contracting operations within the MHS.

III. METHODOLOGY

A. INTRODUCTION

This chapter describes the methodology used to establish the research paper's foundation to answer the proposed research questions. The research includes a literature review that covers Kotter's Change Theory, multiple GAO reports, the NDAA 2017, and other government material related to the DHA transition process. This chapter first explains the contracting capability of DHA and each service component. The goal is identifying any similarities in systems or processes in which DHA aims to adopt. The further analysis identifies various contracting authorities and DHA's ability to create or leverage existing authorities. The goal is to assess DHA's contracting posture at the inception of the administrative responsibility of MTFs. Next, this chapter explains the data collection process from one of the MTFs identified as part of the transition. The data from the MTF was then used to identify trends that coincide the transition, from inception to present. The results of the trends will then be analyzed against DHA's efficiency measures. Additional data will address the use of the MQS vehicle (Defense Health Agency, 2018-b). MQS is a DOD-wide strategic sourcing vehicle that serves an Indefinite Delivery/Indefinite Quantity (ID/IQ) awarded as a Total Small Business Set-aside (DHA, 2018). The goal is to identify trends in cost-savings through the use of this mandated vehicle. Last, the data will address DHA's requirements portal. The goal is to identify if the use of the consolidation portal produces efficiencies in processing time. The next section discusses the development of the DHA transition database.

B. DEVELOPMENT OF THE DHA TRANSITION DATABASE

1. Sources

Data gathering began by reviewing the public release of the 2017 annual report of the NDAA by the 116th Congress, which directed DHA to take administrative control of all MTFs formerly. From this information, we obtained public documents from the DHA website. These documents, town hall presentations, policies, and congressional testimony referenced DHA's role as outlined in the NDAA. Also, the documents identified key

stakeholders that would take part in the new reform. To collect an adequate amount of information which led to the release of NDAA 2017, multiple GAO reports dated before the release of the NDAA 2017 were collected and reviewed. The goal of this collection was to identify common themes. These commonalities centered on the terms "consolidation, efficiency, cost-savings, reducing redundancies, and streamlining." For this research paper, we sought acquisitions and contracting information to support the purpose of this paper. Through DHA-related websites and SharePoint, a copy of DHA's Implementation Plan 3 was obtained. DHA's Implementation Plan 3 was the key document that sourced a majority of the research. Appendix 7: Acquisitions of the DHA's Implementation Plan 3 specifically provided the framework for DHA's process of assuming acquisition authority from each of the service components. Next, each service components' website was visited to obtain information about the transition. Here, contracting capabilities, roles, and responsibly information were collected regarding roles and responsibilities. The goal for this information is to identify the differences and similarities in contracting capabilities of the service components and analyze how those capabilities and processes will be optimized and consolidated in support of DHA assuming administrative control of MTFs.

2. Alignment to Research Question 1

To help answer the research questions, we utilized multiple data tools within the Army acquisition community. These tools included the FPDS-NG, VCE, PD2, PIEE, and Beta.Sam.Gov to gather contracting metrics. To answer the first research question "How has the contracting capabilities and processes from each service component been affected upon inception of DHA assuming administration responsibility of MTFs on 1 October 2018?," we compared the contracting capability of DHA and each service component before the release of NDAA 2017 and post-release of NDAA 2017. The goal was to identify the process or method that DHA would employ to consolidate the contracting process upon being designated as the administrative lead agent as of 1 October 2018. As part of the consolidation efforts for contracting and acquisitions, DHA required the use of its requirements portal for submission of all contracting requirements from MTFs. To analyze if this requirement process streamlined or created time-saved or administrative efficiencies, the requirements process from the DHA website was collected and information for service components to be

submitted. The information was then compared to the current Procurement Acquisition Lead Time (PALT) in use by the Army Contracting Command (ACC) and the USAHCA. In addition, the number of contracting actions performed by the Navy and the Army were highlighted to demonstrate if the DHA requirements process, as it stands, results in efficiently processing time for contract administration.

3. Alignment to Research Question 2

To answer the research question, "Is DHA gaining the desired efficiencies in acquisitions and procurement operations?" we analyzed contracting data of WAMC, the first Army MTF that has fully-transitioned to DHA. The goal of the contracting data was to identify and analyze trends in respect to DHA's Quadruple Aim initiative of lower-cost.
The data collected from WAMC would then be compared to the contracting data of other MTFs that have not completed the full transition to DHA. The point here was to analyze contracting costs over a 4-year period to see which MTFs decreased spending, ultimately achieving cost-savings.

4. Alignment to Research Question 3

To answer the third question, "Does MQS generate cost savings?," the data collected from VCE-BI strictly targeted MQS contracts. Contracts were able to be filtered by the Product Service Code (PSC) code of Q200 to Q500. From VCE-BI, data was pulled from seven MTFs, included WAMC. Once collected, the contract award amount was compared to the national and market value of that provider. The approach here was to compare what the government paid to the market value, both national and by MTF market location. The goal of this data was to address the research question and determine if this mandated contract vehicle generates cost-savings.

C. SUMMARY

This chapter discussed the methodology for this research. The chapter addressed the sources used to build a database to support the literature review. The next chapter discusses the findings and analysis of the research. Last, the chapter addresses recommendations based on the findings.

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IV. FINDINGS, ANALYSIS, AND RECOMMENDATIONS

A. INTRODUCTION

This chapter discusses the findings, analysis, and recommendations with regards to the research questions introduced in Chapter I. First; the information addresses how the services contracting operations and processes will be affected by the MHS reform. The information will highlight the contracting operations of each service stakeholder before and after the release of the NDAA and analyze DHA's actions taken to consolidate this effort. Next, the chapter will address the efficiency of DHA's acquisition and contracting strategy through the lens of their Quadruple Aim initiative. The following information will analyze contracting data from Womack Army Medical Center, the first Army MTF to complete ADC under DHA, and compare the contracting data against a sample of MTFs that have not completed the full transition. The goal is to identify spending trends, contracting opportunities, and other developments resulting from the data presented.

Additionally, the information will address if the MQS contracting vehicle generates cost-savings. The data will assess the effectiveness of this mandated contracting vehicle by analyzing recent awards. The information will draw comparisons and differences in the use of MQS against market costs for medical providers. Finally, we present recommendations based on research results.

B. FINDINGS

The DHA Transition Database contained multiple supporting documentation, tables, and figures representing DHA's efforts to assume ADC of all MTFs. Also, three different contract administration systems were used to validate contracting data. Additional data was collected over four years of market patterns and trends of medical provider services and specialties. The figures and tables within reflect the analysis of total contracts awarded, contracts award using the MQS, and average market costs compared to what the government paid.

(1) How has the contracting capabilities and processes from each service component been affected upon inception of DHA assuming administration responsibility of MTFs on 1 October 2018?

The section presents data that we gathered to answer the research question, "How will the services contracting operations and processes be affected by the MHS reform?" The findings compare the service components and DHA's contracting operations and practices before and post-enactment of NDAA 2017.

a. Pre-NDAA 2017 DHA Contracting Operations Overview

The mission of DHA is to "lead the MHS integration of readiness and health to deliver the Quadruple Aim: increased readiness, better health, better care, and lower cost" (Military Health System, n.d.-a). Currently, contracting operations reside in the DHA J-4 Acquisition section and have the ability to perform contracting administration within their agency. Also, DHA can conduct:

- Acquisition Process Support
- Strategic Acquisition Program Management
- Acquisition Policy and Control
- Head Contracting Activity/Contracting Operations (Military Health System, n.d.-b)

Most of DHA's contracting authority comes from the CAE who provides oversight and approval of all acquisition matters for the agency (Military Health System, n.d.-b). In addition to the areas listed above, DHA can "administer, product conceptualization, program initiation, design, development, test, production, deployment, logistical support, modification, and product disposal" (Military Health System, n.d.-b). The next section describes the USAHCA organization and its contracting operations before the release of the NDAA 2017.

b. Pre-NDAA 2017 USAHCA Contracting Operations Overview

USAHCA is the direct contracting arm of Army Medicine. The Headquarters is located at Joint Base San Antonio, Texas, and supports a tri-service beneficiary population of service members, family members, and retirees (United States Army Health Contracting Activity [USAHCA], n.d.). Contracting authority for the organization is provided by the ACC. The Army's standard system for contract writing is PD2. The organization is known for the administration and award of health services and medical supply contracts. Some of these procurement actions include: nurses, transcription services, laboratory services, imaging maintenance services, physicians, dentists, pharmacists, ancillary services, hospital housekeeping, laundry, linen distribution, regulated medical waste, and contracted advisory/assistance services (USAHCA, n.d.).

For contract filing, USAHCA utilizes the VCE Paperless Contract File (PCF), which is a secure, web-based virtual contracting office with a structured file format that provides transparency to Army's leaders (Virtual Contracting Enterprise, n.d.). For uniformed acquisition policy, the organization utilizes the Federal Acquisition Regulation (FAR) and the Defense Federal Acquisition Regulation Supplement (DFARS). For service-specific policies and regulations, USAHCA references the Army Federal Acquisition Regulation (AFAR). USAHCA's organizational alignment is distributed across multiple markets to support all Army MTFs (CONUS and OCONUS). Figure 12 illustrates the current Common Operating Picture (COP) of the organization.

The market-based alignment creates a direct line of support between the customer and the medical contracting branch within their geographic location. Last, the organizational construct is designed to support both Garrison and Operational Contract Support during contingency operations. Next, the information will describe the contracting operation of the Navy.

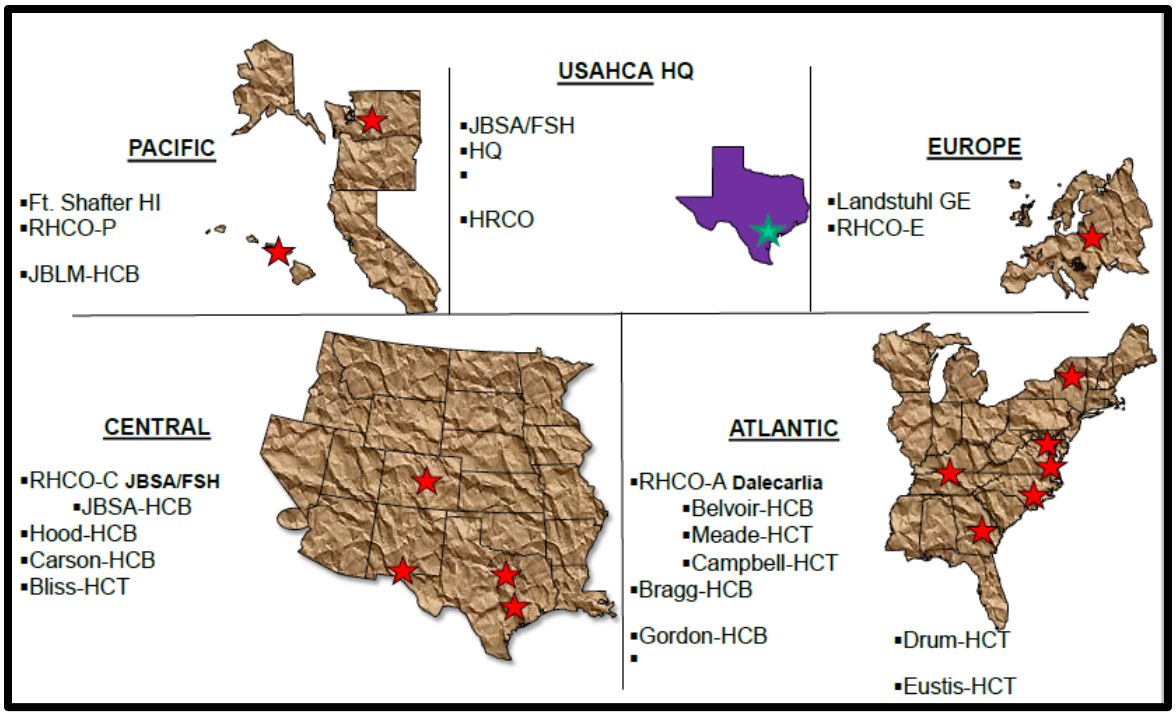


Figure 12. USAHCA Common Operating Picture. Source: USAHCA (2020).

c. Pre-NDAA 2017 Navy BUMED Contracting Operations Overview

The Navy BUMED provides command and control over all Navy medicine. The NMLC directly reports to the BUMED and oversees the Navy's medical contracting mission. The BUMED's Senior Contracting Official (SCO) is seated down at the NMLC and receives their contracting authority from the Naval Supply System Command (NAVSUP) HCA (Naval Medical Logistics Command [NMLC], n.d.-a).

Within the NMLC is the Acquisition and Analytics Directorate, which "develops and executes contracts for health care services, supplies, and equipment; medical research and development; information technology support" for the "expeditionary medical facilities, and shore-based treatment facilities worldwide" (NMLC, n.d.-b). The NMLC centrally owns the assets (e.g., contracting, technical and legal) for Navy medicine. This unique capability allows the MTF customers to work alongside the assets mentioned before in identifying requirements and developing solutions early in the acquisition planning phase. For Contract Administration, the organization utilizes the Standard Procurement System (SPS), also referred to as PD2. For a unified acquisition policy, the contracting

activities reference the FAR and DFARS, and for service-specific policies and regulation, the BUMED references the Navy-Marine Corps Acquisition Regulation Supplement (NMCARS).

d. Pre-NDAA 2017 Air Force Contracting Operations Overview

The United States Air Force Medical services, unlike the Navy and Army, do not have a separate medical contracting organization that supports the Air Force MTFs. The 773d Enterprise Sourcing Squadron, which is part of the Air Force Installation Contracting Center (AFICC), "provides enterprise-wide medical acquisition support to the Air Force Medical Service (AFMS)" (Wright-Patterson AFB, 2019). Each installation contracting squadron (CON) provides contracting support for necessary medical supplies and services to support each clinic located on that installation.

The Air Force Head of Contracting authority lies with the Deputy Assistant Secretary of Contracting (DAS(C)). For contract administration, the Air Force uses ConWrite and is currently in the process of transitioning over to the Con-IT system. For contract filing, the Contract (KT) File share, an electronic paperless contracting file system, is currently being implemented for use. For a unified acquisition policy, the contracting activities reference the FAR and DFARS. For service-specific policies and regulations, the contracting activities reference the Air Force Federal Acquisition Regulation Supplement (AFFARS).

e. Post-NDAA 2017 (1 October 2018-Present)

The Army, Air Force, and Navy contracting operations and processes remained virtually the same. Each contracting activity continued to support to their designated MTF or medical clinics with very little or no interception from DHA. Specifically, the transfer of function (TOF) for contracting remained intact. However, DHA has issued DHAPI 5000.01 MHS Request Submissions Portal, which "[notifies] and instruct stakeholders across the MHS of the newly integrated submissions and request portal and submissions process which went fully-operational 1 October 2018" (Defense Health Agency [DHA], 2020).

(1) How is DHA gaining the desired efficiencies in acquisitions and procurement operations after achieving ADC?

The section presents data that we gathered to answer the research question "Is DHA gaining the desired efficiencies in acquisitions in contracting operations?" The findings will highlight seven MTFs and identify spending trends in comparison of contract dollar obligated. DHA defines efficiency in contracting through the Quadruple Aim initiative, as described by the DHA CAE Dr. Butler. This comparative analysis aims to demonstrate if a reduction in costs is occurring under DHA's Quadruple Aim initiative to lower costs.

a. Data Collection of Total Contract Dollars Spent for WAMC

WAMC in Fort Bragg, North Carolina, is one of the seven MTFs to transition full ADC to DHA as of 1 October 2018. The team queried data from VCE-BI on eight Army MTFs; WAMC, Brooke Army Medical Center (BAMC) San Antonio, General Leonard Wood Army Community Center (GLWACH) Fort Leonard, Carl R. Darnall Army Medical Center (CRDAMC), Bayne-Jones Army Community Center (BJACH) Tripler Army Medical Center (TAMC), and McDonald Army Health Center (MAHC). We chose WAMC as it was the first Army MTF to transition ADC to DHA to include budgetary functions. BAMC, CRDAMC, and TAMC were selected to show a comparison of MTFs that have not transitioned budgetary functions but are categorized to operate in a large market. GLWACH, BJACH, and MAHC were chosen to show a comparison of small market MTFs that have not yet transitioned budgetary functions either.

As part of DHA's financial management reform, WAMC being in the first wave of MTFs transitioned over to DHA is receiving funds straight from DHA with a transitional Intermediate Management Organization (tIMO) in place as seen in Figure 13 (Defense Health Agency, n.d.-a). The tIMO serves as a temporary organization to assist and oversee the transition of the first wave. The intent of the new funds process is to "standardized financial management practices" to produce information that is readily accessible and reliant for DHA to maintain "accountability over DHP's extensive resources and efficiently and economically manage the MHS's assets and budgets" (Wilkie, 2018).

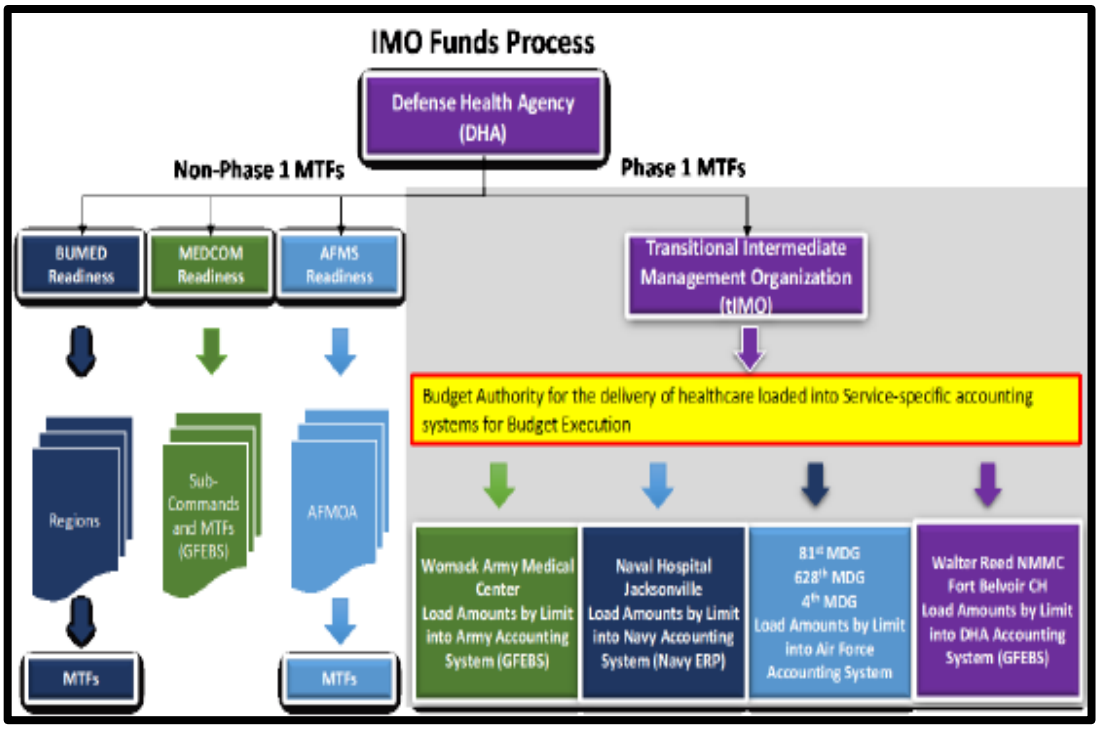
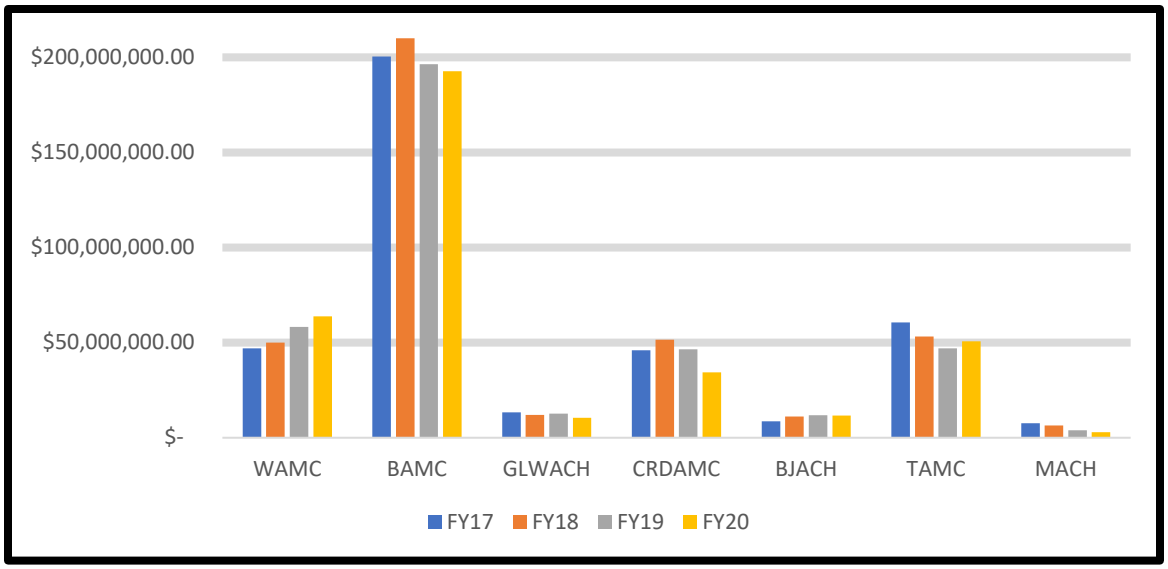


Figure 13. IMO Funds Process for Phase I MTFs. Source: Wilkie (2018).

Figure 14 depicts the total contract dollars spent from the MTFs previously mentioned from 1 October 2016 to 3 May 2020. As illustrated, there has been a noticeable increase in WAMC spending post-transition to DHA of approximately $5 million from FY 19 to 3 May 2020 of FY 20. Concurrently the other MTFs have steadily seen a decrease in spending. Categorically we lack sufficient data to understand why spending has increased in WAMC. However, we recommend in our future study area this area is further investigated to find out the real reason for the spending increase at WAMC upon their transition to DHA.



*The informational data is from VCE-BI, 2020

Figure 14. Total Contract Dollars Obligated for FY17- FY20 (1 October 2016 to 3 May 2020)

(1) Does the MQS strategic sourcing vehicle generate cost-savings?

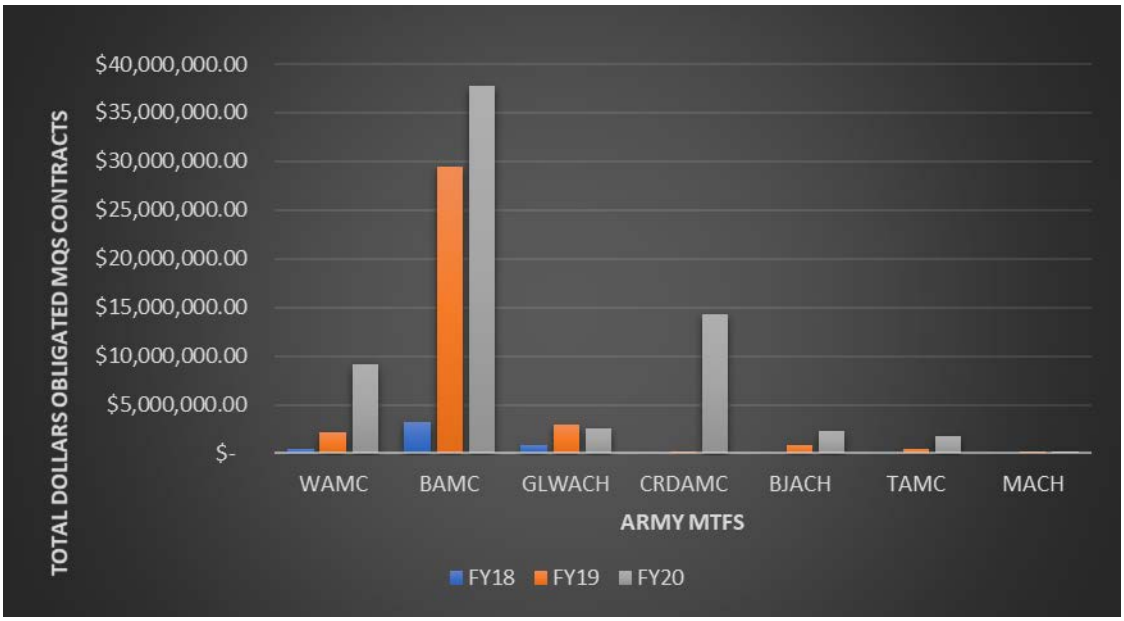
The section presents data that we gathered to answer the research question, "Does the MQS strategic sourcing vehicle generate cost-savings?" The findings will look at the latest DHA Interim Procedures Memorandum (IPM) 18–008, which instructs "MTFs and servicing contracting offices to use the DHA MQS contracts for the procurement of health care staffing requirements for market segments of a physician, nurse, dental, and ancillary contract services in the United States and its Territories" (DHA, 2018).

a. MQS Mandated Usage

The MQS vehicle is a result of section 727 of NDAA 2017 which requires "a common set of mandatory-use professional staffing contracts for all MTFs that provide direct care" (Wilkie, 2018). DHA-IPM 18–008 further highlights that utilizing the DHA MQS contracts to fulfill health care professional staffing requirements at MTFs is the most advantageous method of fulfilling the government's needs, price, and other factors considered.

> Notably, across-the-board utilization of the DHA MQS contracts will reduce duplication and fragmentation of professional staffing requirements; standardize administrative, management, and clinical practices across the MHS; and drive rate, process, and demand-based cost savings for the DOD. (DHA, 2018)

Figure 15 depicts the total dollars obligated to MQS contracts across seven MTFs representing both large and small markets. Since the implementation of the strategic vehicle in April 2018, there has been a noticeable uptick in the use of the vehicle to procure a mixture of high- density, low-cost providers and low-density, high-cost providers.



*The informational data is from VCE-BI, 2020

Figure 15. MQS Contract for Army MTFs

In lieu of pricing agreement DHA has established four key performance parameter (KPPs) to measure the effectiveness of the MQS vehicle: 1) overall fill rate; 2) on-time fill rate; 3) turnover rate; and 4) replenish rate (Wilkie, 2018). The goal is to fill vacancy positions with qualified individuals.

C. ANALYSIS OF FINDINGS

The following section will discuss the findings and answer the research questions. We analyzed data gathered on medical service contracts from the FPDS-NG and VCE-BI from Fiscal Year (FY) 2017 through 3 May 2020 of FY 2020. We gathered the data to determine the number of medical service contracts that were purchased during the specified timeframe and total dollars obligated. To validate the reliability of the findings, we looked for apparent errors and missing values and determined the data was adequate for our analysis. Other findings that were not previously revealed earlier in the research will also be discussed.

(1) How has the contracting capabilities and processes from each service component been affected upon inception of DHA assuming ADC of MFTs on 1 October 2018?

As each service component supports their MTF upon inception of administrative responsibility of the MTFs, DHA established mechanisms to prevent disruption in contracting operations and support during the transition process. The following sections will identify and describe those practices in further detail.

a. Memorandums of Agreement (MOA)

Contracting operations is one of the critical functions that remained unaltered upon inception of administration and management control to DHA. This continuity was credited to signed MOAs between the services and DHA. These agreements provide direct contracting support to MTFs without mission impact. Furthermore, the MOAs establish roles and responsibilities between DHA and the service components with regards to acquisition support to the MTFs. The goal is to maintain a unified effort through the enterprise.

b. Transitional Intermediate Management Organization (tIMO)

Simultaneously, DHA established the first tIMO. The mission of the tIMO is to "enable an integrated system of readiness and health by supporting and holding accountable assigned MTFs to optimize the delivery of the Quadruple Aim" (DHA, n.d.-

a). Soon after its inception, the tIMO assumed ADC of the first seven designated MTFS. One of tIMO responsibilities is to provide oversight of the MTFs ensuring a seamless transition into the DHA market structure (Defense Health Agency, n.d.-a). Figure 16 illustrates this organizational structure as part of the transition for phase one.

As previously stated, the tIMO is established to provide oversight of the initial transfer of the seven MTFs into the market structure. From 1 October 2018 to 1 October 2019, the Director of DHA is also duel-hatted as the Director for the tIMO. The tIMO was tentatively planned to dissolve upon the activation of the market structure in October of 2019. However, concerns were raised by the leadership about transition readiness (Gilbert, 2019). As a result, DHA directed the continuation of tIMO operations and awarded a six-month contract to Booz Allen in August 2019. According to the contract, a description of requirements included administration and planning services for logistics, information technology, personnel, patient safety, quality, and Health Insurance Portability and Accountability Act (HIPAA) compliance, supporting the tIMO.

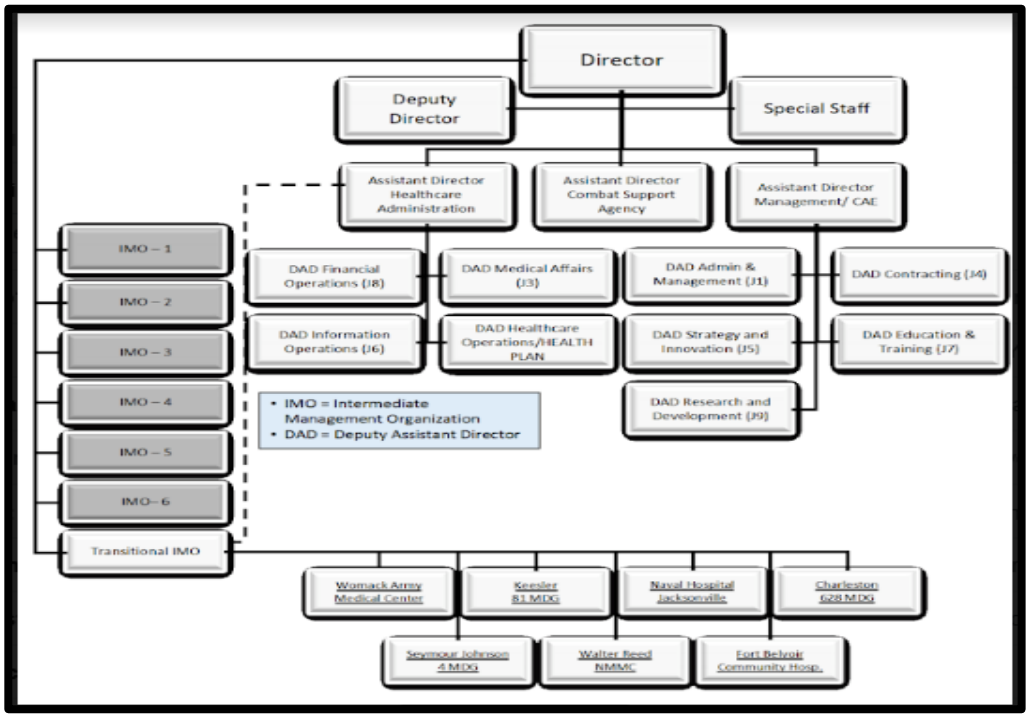


Figure 16. Phase I Transition. Source: Wilkie (2018).

c. MHS Request Submissions Portal (DHA, 2020)

The DHAPI 5000.01, Implementation of the MHS Request Submissions Portal and Process, "notify and instruct stakeholders across the MHS of the newly integrated MHS Request Submissions Portal and submissions process" (DHA, 2020) which went active as of 1 October 2018. According to the MHS Request Submissions Portal:

> The Defense Health Agency (DHA) established a single, standardized request submission portal known as the Military Health System Request Submission Portal (MHSRSP), which aims to better support the overall requirements management process and, as a result, help enable the Military Health System (MHS) to achieve the Quadruple Aim. The key intended outcomes for the MHSRSP tool include: Standardized identification of capability needs/gaps and generation of cross-organizational, unified requirements; Improved traceability and visibility into requests and requirements; Cost savings and avoidance; and Improved overall organizational efficiency and effectiveness. (DHA, n.d.-b)

Figure 17 provides an illustration of the request submission process flow. DHA established an MHS Requirements Management Knowledge Exchange website, which provides training on the submission process. The submission process includes "triage teams representatives comprised of a Request Manager, Assistant Director (AD)/Deputy Assistant Director (DAD) Representatives, and others who are responsible for reviewing initial MHS request submissions, assigning functional ownership, and facilitating the completion of Triage" (DHA, n.d.-d).

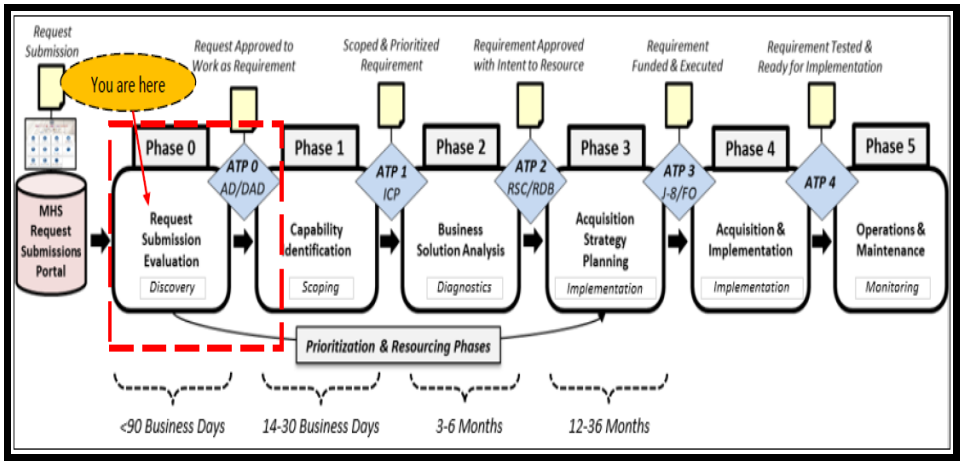


Figure 17. MHS Requirements Management Overview. Source: DHA (n.d.-d).

Currently, USAHCA has utilized the portal only for the submission of MQS requirements. No other medical requirements from USAHCA has been routed through the portal as of yet. For FY 2019, USAHCA had over 4,748 contracting actions alone. These actions ranged from new requirements to modifications for deobligations. The NMLC had approximately 3,451 actions. The Air Force data was not as easily accessible as it does not have a designated medical contracting office. The Triage teams, per the DHA website, consists of 3–4 representatives for each service. The requirement submission timeline indicates it should take less than or equal to 90 business days, less than or equal to 45 business days for requests to be fast-tracked and less than or equal to seven days for platinum requests, which consist of time-sensitive requests (DHA, n.d.-d).

According to the timelines and the number of requirements per service for one FY, the DHA team's workload will be stretched to maximum capacity. Furthermore, requirement end users will have to incorporate the submission timeline into their planning process to ensure the timely delivery of services and supplies and prevent disruption in services. Contracting activities will no longer receive requirements straight from the end-user, and it will be filtered through DHA first.

According to DHA's 2018 Stakeholder report, since the initiation of the portal, they have processed an estimated 30 requests per day with an average turnaround time of 46 business days requests stay in phase 0. Of note, the Deputy Assistant of the Army (Procurement) published FY19 PALT initiatives for all Army Contracting Activities (HCAs) and Program Executive Offices (PEOs). The goal for medical spending categories is 90 days. Until DHA completes a total TOF of acquisitions and contracting, each contracting activity will continue to follow its own published procurement lead time. As a result, the projected timeframe for requirements process submission may impact the individual services PALT to complete a requirement.

(1) How is DHA gaining the desired efficiencies in acquisitions and procurement operations?

Currently, until TOF of acquisition, each service utilizes MQS to attain services for their supporting MTF. Until TOF and DHA market offices are established, each service

will continue to carry on business as usual. As a result, this will continue to create competition unintentionally between the services to fill Full-Time Equivalent (FTEs), driving up cost. The MTFs should not hold any buying power. The MHS contracting requirements for personal and non-personal services should be centrally owned by each of DHA's market offices to increase the market's buying power.

a. Spending Trends

According to the FY 2018 DHP Agency Financial Report, the civilian health care market and the DHP activities correlate with one another. The increase in spending for WAMC demonstrates a cost-trajectory of human capital which is not aligned with the messaging of reducing costs and improving fiscal efficiency. To improve these trends and identify market patterns contracting personnel (officers) should posture next to MTF Commanders; to provide direct business advisement. Establishing this line of communication is critical; considering a majority of an MTF's budget is comprised of contracted supplies and services. In a majority of facilities, more than 60% of the critical care service is achieved through contracting. Without contracts, the MHS will be inoperable.

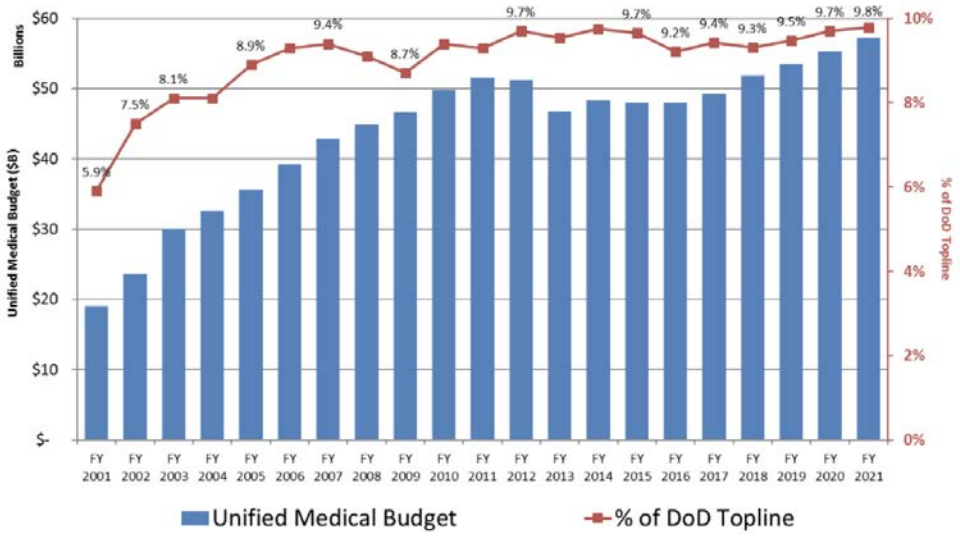


Figure 18. Military Medical Costs as a Percentage of the DOD Budget. Source: Defense Health Program (2017).

b. Enterprise-wide Contracting Capabilities

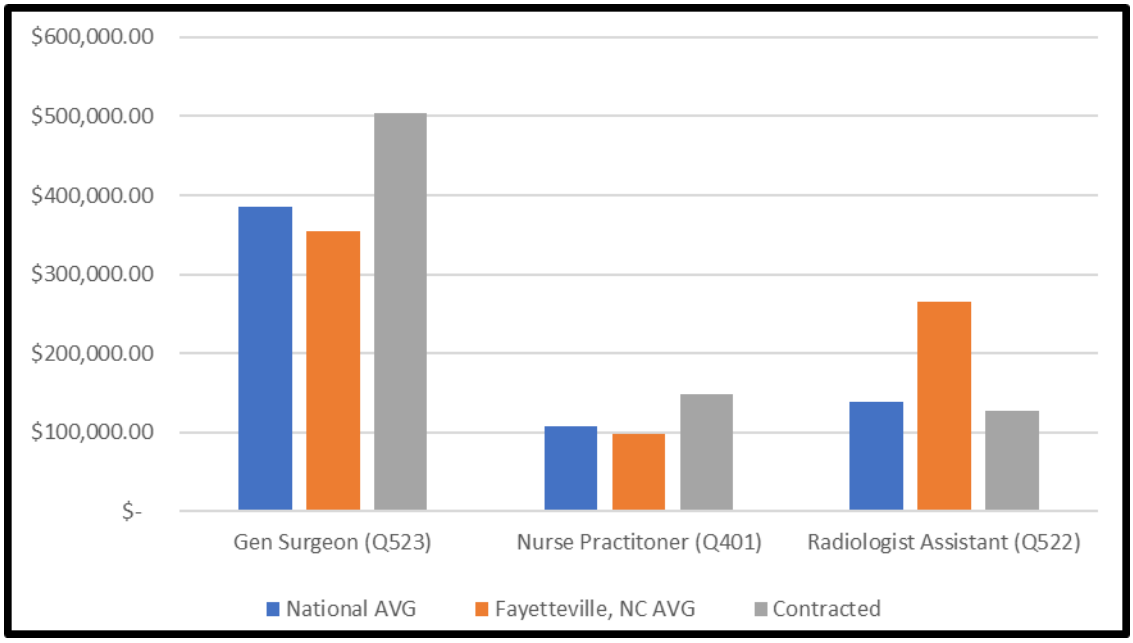
Upon the enactment of NDAA 2017, there are no enterprise-wide contracting capabilities that all the service components use. As stated in the findings for research question one, different contracting writing systems and resource planning systems are used by the Air Force. Soon the Navy and Army will be deploying a new platform for contract writing, which will be Army Contract Writing System (ACWS) that will interface with the General Fund Enterprise Business System (GFEBS), an Army web-based resource planning system (US Army PEO, n.d.) According to the DHA Stakeholder report, "66% of Defense Health Program (DHP) funding now executes from a singular financial accounting system." In FY21, the BUMED is expected to complete the deployment of GFEBS, increasing the percentage to 85% (DHA, 2018); however, as of the timeframe of this research, no information could be found that indicates the Air Force utilizing the same financial system. Without the Air Force deploying the same systems, it will be challenging to meet its goal to "standardize, streamline, and share critical data to improve decision-making and audit readiness across the enterprise" (DHA, 2017) in terms of tracking DHP funds.

(1) Does the MQS strategic sourcing vehicle generate cost-savings?

a. No Established Price Agreement for MQS

The use of the MQS vehicle may produce gains in efficiencies in the contracting process as a result of the direct and accessible vetted pool of contractors. However, the use of the contract vehicle did not generate gains in cost efficiencies through the contracting systems used to pull data within this research report. The market reflects current costs upon the time of a valid requirement. As a result of this relationship, contracting per FTE, especially for specialty services, can be costly. Currently, services are obtained based on the need of each MTF on an individual basis giving each MTF the ability to decide what to buy and when to buy. Based on our findings, the MHS contracting requirements for personal and non-personal services should be centrally-owned, consolidated, and managed to increase the government's posture through improved tradecraft in the acquisition for services.

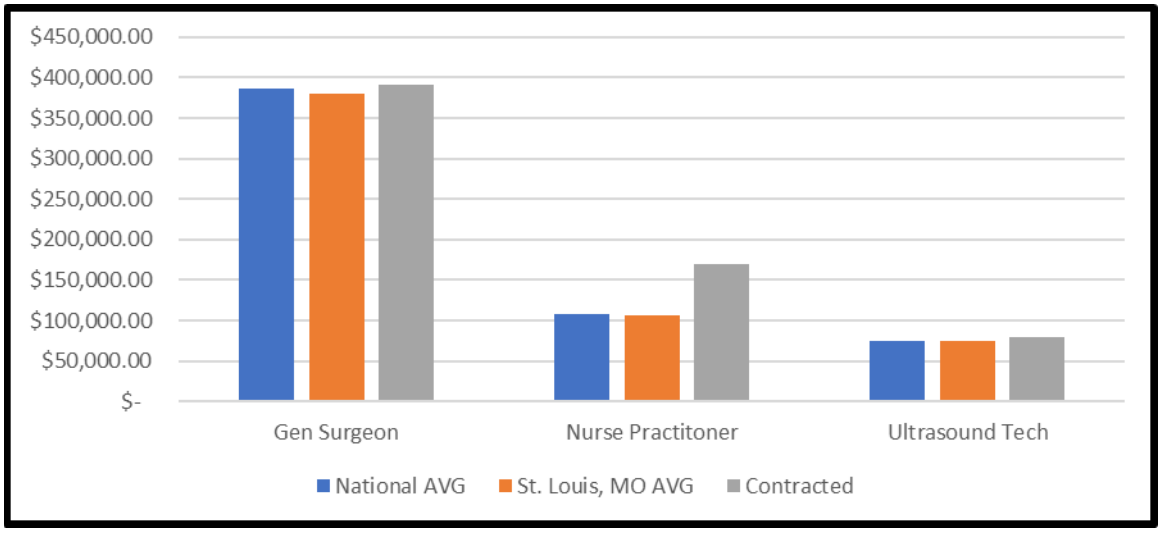
DHAs Market construct plan does demonstrate this; however, until DHA acquires complete ADC of the MTFs, each service will continue to carry on business as usual and utilize MQS to attain services for their supporting MTF only. As a result, this will unintentionally create competition between the services to fill FTEs, which drives up cost. Figures 19 and 20 depict comparisons of salaries for commercial and military contract medical providers in a given area. Figure 19, we compared the national average, Fayetteville, NC average, and contracts awarded for three medical providers general surgeon, nurse practitioner, and radiologist assistant. The data showed that the Army paid above the national and local area market value for two of the three providers. Of note, several factors may contribute to this cost premium. For example, the market in Fayetteville for a specific specialty provider may be scare compared to Raleigh, North Carolina. Furthermore, an MTF, such as BAMC, may have a better buying advantage to acquire a specialty provider given that San Antonio is figuratively considered to be a hub for medical specialties. These markets demonstrate that at any given time, the government may be susceptible to cost premiums in order to maintain medical care capabilities.



*The informational data is from VCE-BI, 2020

Figure 19. Comparison of Salaries for Commercial and Military Contracted Medical Providers in FT Bragg, NC

In Figure 20, we compared the national average, St. Louis, MO average, and contracts awarded for three medical providers general surgeon, nurse practitioner, and an ultrasound technician. The data showed that the Army was paying close to or a little above the national and local area market value for two of the three providers. Some of these differences in costs may not include the indirect costs, such as administration, security, and overhead. The goal of the data is to illustrate trends and identify gaps in costs and pinpoint high costs services for capability and planning considerations.



*The informational data is from VCE-BI, 2020

Figure 20. Comparison of Salaries for Commercial and Military Contracted Medical Providers in FT Leonard Wood, MO

Figure 21 illustrates a future projection in the shortages of physicians from 2013 to 2025. The Association of American Medical Colleges (AAMC) revised projections saw a shortage between 46,100 and 90,400 physicians (Managed Care, 2016). Bottom-line, a multiple-award contract for medical services, will be hard to generate cost savings if the supply cannot keep up with the demand. The government will continue to pay the market value or above to attract and retain healthcare professionals.

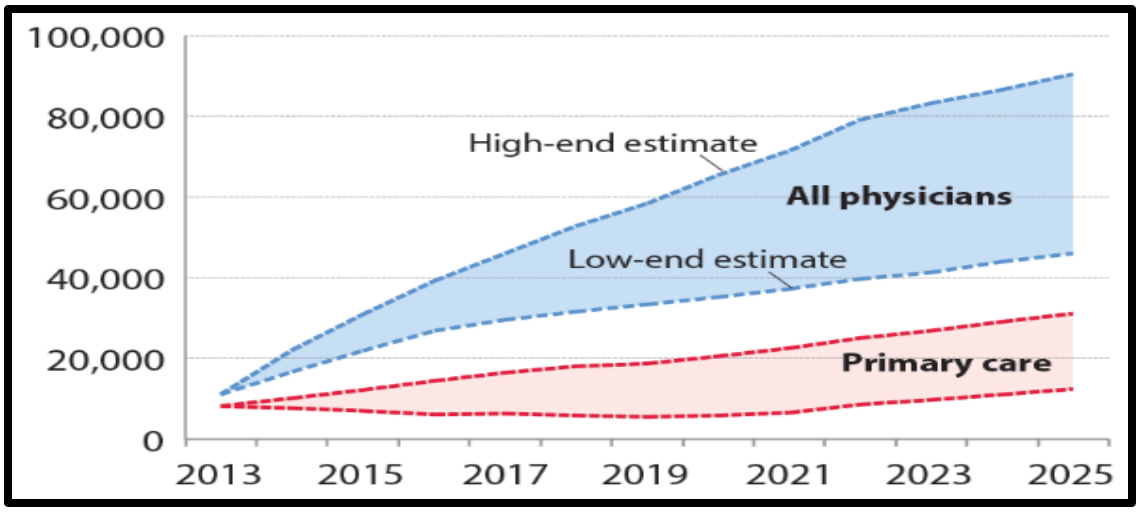


Figure 21. Projected Physician Shortage. Source: AAMC (2016).

D. RECOMMENDATIONS

Based on the research findings, these recommendations focus on maximizing existing operational capabilities and processes and increasing contracting efficiencies. If any of the recommendations are implemented, they may increase efficiency, streamline requirements, and reduce costs while maintaining a high level of medical capability.

1. Designate One Lead Agent for Medical Contracting

As addressed in the findings and analysis section, each service component continues to operate and administer medical contracts, even while in the same geographically-aligned market. For example, the USAHCA's Regional Health Contracting Office-Central located in San Antonio, Texas, continues to administer medical contracting for Brooke Army Medical Center (BAMC). In contrast, the 59th Medical Wing of the United States Airforce still administers medical contracts for Wilford Hall Ambulatory Surgical Center. These facilities are approximately 17 miles apart. This continued independence, evidenced through the existing MOU/MOAs, creates unforeseen competition amongst the services when soliciting for the same requirement in a given market. The DOD and DHA should designate a lead agent for all of the medical contracting to eliminate the risk of contract duplication and to take advantage of assets readily available to support their mission.

DHA should identify an organization that is the subject matter expert in medical contracting and can support operational and strategic requirements. Also, the designated organization should have the organizational structure to support DHA's market construct geographically. The organization should be SCO-led to assure compliance with the procurement systems, provide policy, advice, guidance, resolve contracting problems, and monitor competition and socioeconomic programs. The lead agent should provide medical contracting support for medical centers, acquisition support for selected centralized command-wide medical personal and non-personal services contracts, and other command-wide projects/programs. Furthermore, the organization should consist of an extensive and efficient acquisition approval strategy process, from simplified acquisitions to above Simplified Acquisitions Threshold (SAT) requirements. Also, the organization should possess a Government Purchase Card (GPC) Program and have the capability to host strategic requirement conferences and source selection acquisitions. Until a lead organization is designated, each of the services will continue to operate independently; increasing competitive costs amongst the services and reducing the ability to consolidate.

2. One Vendor per Specialty to Service all MTFs

Although the use of the MQS contract vehicle is mandated, its usage does not generate cost-savings from an award-cost perspective; evidenced through the data in the findings and analysis. However, from a contract administration perspective, the timeframe to administer awards utilizing MQS, theoretically, should take less time; vendors are already vetted to do business with the Government. Since the price is not set for MQS contracts, most proposals from contractors reflect the current market value at the time of government's request. As a result the government is not advantageously postured and is forced to pay what the market bears at the time of the award. Consequently, the projected cost for a specialty provider may be one of the last factors considered when deciding to provide the capability or not.

Knowing these factors, coupled with market volatility, DHA should consider the Dental Services Support MQS waiver that was submitted from the Army for dental services. The Army dental community faced fluctuations in requirements, which resulted

in the inability to accurately forecast the number of personnel necessary to maintain dental support services. Due to these fluctuations, the use of the MQS vehicle could not be utilized efficiently. As a result, an MQS waiver was submitted and approved. Upon approval, the Health Readiness Contracting Office's (HRCO) conducted a formal source selection process, which resulted in an award to a single contractor to fulfill requirements in Region 1; Central Region, Alaska, and Hawaii Dental Activities (DENTAC), and Region 2; Atlantic Region DENTACs. In total, 35 DENTACs with 444 Contract Services Providers (CSPs) are supported. This was an increase in 49 CSPs from the initial award in December 2018. DHA may want to consider the same approach for Nurses, Physician Assistants, or Nurse Practitioners. This approach may save time in administering one award as opposed to, perhaps, 444 personal service contracts and ultimately reduce contract risk.

3. Full-Service Line Delivery

Another recommendation will be to change the MQS concept and to contract for the actual service instead of an FTE to one prime vendor. This method will set prices per that market and save the government money. This concept will allow for a more efficient option to maintain core services while sustaining readiness and critical ancillary services lines. One of the benefits of contracting complete product/ service lines is that the government and contractor can establish a resource-sharing agreement to utilize government-furnished space in the MTF to treat beneficiaries. This concept will ultimately reduce contract manpower costs and allow the DHA to focus on the Core Services that support readiness. Additionally, this solution enhances efficiencies in beneficiary access to care, improves Command and Control, strengthens the relationship between the MTF and installation support, facilitates readiness, and decreases travel distance between soldiers and family members for treatment. This acquisition strategy has Tri-Service applicability and can serve as a long-term solution as DHA assumes control of all MTF budgets and health care management from the Services.

4. Military Medical Acquisition Support

To assist DHA with its core capabilities for acquisitions and procurement support, the agency should consider military medical personnel to lead the departments below:

- Acquisition Process Support
- Strategic Acquisition Program Management
- Acquisition Policy and Control
- Head Contracting Activity/Contracting Operations (Military Health System, n.d.-b)

The military personnel should be Defense Acquisition Workforce certified in their requisite career fields. They should also possess on-the-job experience (i.e., U.S. Army Medical Materiel Agency, U.S. Army Medical Materiel Development Activity, U.S. Army Health Contracting Activity, and other DOD organizations). The personnel can assist in the overall development, implementation, and management of procurement programs concerning the total MHS. If warranted, military medical personnel can action contracting agreements with a wide variety of corporate/government entities while posturing the departments to support Garrison operations and deployment support during contingency operations effectively.

5. Joint Medical Command

More than 30 years ago, the 100th Congress held a hearing on the Implementation of a Joint Medical Command. Some of the key testimony included phrases, such as "cost-savings, consolidation, and cross-utilization" (*Implementation of Joint Military Medical Command,* 1987). These same elements hold true today. The concept of one single command, Defense Health Command, to oversee DHA and the services' surgeon generals. Having one command through this transition would improve synchronization between DHA and the services. Currently, MTF Commanders still report to a surgeon general and, often, are involved in the strategic decisions of the MTF, which can be both positive and negative. For further insight, reference COL Anthony R. Nesbitt's 2012, the United States Army War College Strategic Research Project. His research concluded that "If we are going to see a change that is truly sustainable and is adhered to and not subjected to interference from parochial service structures, we must have a Joint Unified Medical Command" (Nesbitt, 2012). This concept should be highly considered as part of the effort

to consolidate requirements, reduce redundancies, and lower costs. In times of war, this recommendation can be optimized through the use of shared Title 10 functions, generating a “singular corporate process for making strategic decisions across all services” (Nesbitt, 2012).

E. SUMMARY

This chapter discussed the findings, analysis, and recommendations based on the DHA transition plan analysis. First, the research findings were presented. Next, we analyzed the contracting capability, contracting efficiency, and usage of the MQS contract vehicle. The analysis was then used to answer the research questions. Finally, based on the analysis of these findings, recommendations to enhance contract efficiency and improve the DHA transition process. The next chapter presents the conclusion of our research and identifies areas for further research.

V. CONCLUSION AND AREAS FOR FURTHER RESEARCH

A. CONCLUSION

This research focused on three research questions. The answer to the research questions based on the findings of the research are discussed.

(1) How has the contracting capabilities and processes from each service component been affected upon inception of DHA assuming administration responsibility of MTFs on 1 October 2018?

Through gathered research, the information outlined the contracting capabilities of DHA and each service component. The material addressed capabilities before the release of the NDAA 20017 and identified any major, Tri-Service organizational changes upon inception of DHA assuming administrative responsibility. The goal was to highlight how the contracting capability will be impacted. After analyzing the information, research demonstrated three areas in which contracting capabilities and processes were impacted. First, DHA immediately established MOU/MOAs to ensure a continuous line, stable line of medical contracting support while focusing efforts in other areas of the transition process.

Next, a tIMO was established as an intermediary to aid in a smooth transition by providing oversight during the initial transfer of the MTF to DHA. Last, the information addresses the MHS Request Submission Portal. This single access point for all requirements to be funneled is put in place to streamline and have transparency on all requests. The research highlighted the impact on contracting operations and the DHAs action plan to continue and enhance medical contracting support.

(2) How is DHA gaining the desired efficiencies in acquisitions and procurement operations after achieving ADC?

Through research assessed the efficiency through the lens of the Quadruple Aim initiative. Contracted data were collected from seven MTFs, one of which had fully-transitioned to DHA, WAMC. The information identified spending patterns based on the total contract dollars obligated over four years. Figure 14 illustrated the total contract

dollars obligated for FY17- FY20 (1 October 2016 to 3 May 2020). In addition, the IMO funds process for Phase 1 MTFs was introduced. The information concludes that an increase in spending in human capital for WAMC was not in line with the Quadruple Aim goal of cost-savings. Additionally, the research project discovered the absence of an enterprise-wide contract writing system and a complemented financial system, such as GFEBS. Currently, efforts for collaboration between DHA, the Army, and Navy to standardize, streamline, and share critical data occurs. However, further synchronization between the services to establish enterprise-wide applications is needed to improve decision-making and audit readiness.

(3) Does the MQS strategic sourcing vehicle generate cost-savings?

To answer this research question, information was gathered from VCE which captured the total dollars obligated from the use of the MQS contract vehicle. The information was used to determine the annual usage of the vehicle. Additionally, information compared three medical specialties with current market costs. This result was then compared to what the government paid for the medical specialty. The result concluded that the Army was paying close to or a little above the national and local area market value for two of the three providers. There were little savings to be identified from the use of the MQS contract. The government will continue to pay the market value to retain and attract health care providers, especially in an industry where the demand is exceeding the supply. However, the MQS vehicle will reduce competition amongst the services, standardize practices, and reduce duplication of requirements between the MTFs.

In conclusion, the MHS is complex, but every effort should be made to ensure we are providing world-class care to our service members, beneficiaries, and Forever Soldiers. The impact of a Tri-Service medical solution has been decades in the making. The time for DOD to seize on this opportunity is now. The business decisions that impact medical readiness can pay dividends to support today's warfighters to fight tomorrow's battles.

B. AREAS FOR FURTHER RESEARCH

The findings in this paper identified the need for further research in several areas concerning the transformation of the MHS. Future research areas include further analysis

of the potential of a Joint Defense Health Command to enhance the synchronization/ collaboration between the services and DHA. Another area to focus on for further research would be the MQS contract vehicle. DHA may optimize the use of this strategic, contracting vehicle by contracting for the actual service as opposed to contracting per FTE.

Another area for further research is reassessing each MTF and medical clinic to decide what capabilities are needed to support the military population. This research can address the demographics of the service members for a particular post or airbase and configure, based off of demand aggregation and trends, the medical capability that should be provided (long-term) to that facility. For example, Fort Leonard Wood, Missouri, is mainly known for its basic training population of Military Police, Chemical, and Engineers. There are a small number of other units that are also stationed throughout the post. By studying and analyzing the demographics and medical trends, the DOD can ensure that the right medical capabilities are available at GLWACH. For example, does the hospital need a Neurosurgeon, or does the hospital need more Podiatrists? The results of the research can help to develop long-term solutions for medical capabilities throughout the MHS.

Last, all the information within this research project was collected before COVID-19. Further research on how the pandemic has impacted the DHA transition would undoubtedly be impactful to the entire MHS.

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